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ABSTRACT

This report briefly describes and evaluates a program designed to provide medical and public health consultation to Project Head Start in Massachusetts. The program consisted of teams of community medical and public health professionals made available to Head Start programs for planning and implementation of health programs, and education and training programs for Head Start staff and parents. Evaluative observations and recommendations made by doctors and other consultants in response to questionnaires during 1968 and 1969 are briefly summarized and presented in tabular form. Appendices and attachments (which make up more than half of the document) contain: (1) a table of health services provided in a Head Start program, (2) a sample health program class register, (3) a discussion of evaluation methodology for Head Start health programs, (4) a report on the 1969 National Conference on Head Start and Child Development, (5) the report on the Program of Medical and Public Health Consultation to Project Head Start in Massachusetts (1969), and (6) statistics from the Medical Consultant's Evaluation of Head Start Health Services for the 1969 Summer Head Start Programs in Massachusetts. (BRT)

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report on

Program of Medical and Public Health Consultation to Project... HEAD START ..in Massachusetts

Massachusetts Department of Public Health
February, 1970

PS 008545

Final Report on

PROGRAM OF MEDICAL AND PUBLIC HEALTH CONSULTATION

TO

PROJECT HEAD START IN MASSACHUSETTS

Project Director: M. Grace Hussey, M.D., M.P.H.
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Maternal and Child Health Services
Division of Family Health Services
Massachusetts Department of Public Health

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FINAL SUMMARY REPORT

PROGRAM OF MEDICAL AND PUBLIC HEALTH CONSULTATION TO PROJECT HEAD START IN MASSACHUSETTS

Submitted by: Hedwig M. Sorli, Ed.M., M.P.H.
Project Coordinator

I. INTRODUCTION

Massachusetts continues as the only state which makes a "team" available to its Head Start Programs for health services consultation and program improvement. This constitutes a form of technical assistance designed to involve many health professionals in local planning and implementation of health programs. It also provides for educational and training programs for Head Start staff and parents.

The attachments to this Summary Report are included to constitute an integral part of it. (See Contents.) The data analyzed gives a partial indication of the type of information which has been collected over the approximately two-year interval of time we have been operating the Massachusetts Health Services Consultation Project. Much additional report material and data are on file in our office. A shortage of staff to date has prevented comparative analysis and an in-depth study of the materials. We hope to be able to do this under a new contract with HEW.

Contract #B89-4450 was originally written to terminate on February 28, 1969. At that time we made available twenty-five copies of our Report on the Program of Medical and Public Health Consultation to Project Head Start in Massachusetts in fulfillment of contract requirements. This detailed Report indicates the purpose, scope, and general procedures of the program under which we have continued to deliver the same type of service without interruption or great changes to date.

Two time-extensions were provided after February 28, 1969. The first was the interval extending to September 30, 1969, and the second extension was to February 28, 1970. Although some administrative delays occurred while the mechanics of the extensions were going on (and funds for pediatric payments were tied up), the public health staff at all times carried the consultation as an aspect of their responsibility to community child health programs.

Our Massachusetts Administrative Model can be explained as follows:

CENTRAL OFFICE

Is responsible for Head Start health services consultation, contract development, and program administration.

Supplies a "health consultant team" to each community with a Head Start Program, processes required reports, and provides technical assistance to achieve effective team functioning.

Is responsible for maintaining liaison with all agencies involved at the state and/or regional level, for example, collaboration with appropriate personnel in the OCD Regional Office.

HEALTH SERVICES CONSULTATION TEAM

Is responsible at the local (or community) level for Head Start program review and community assistance in developing, implementing and evaluating an effective health services program for the children enrolled in Head Start.

II. CONSULTATION TEAMS

Our Project has been extremely fortunate in maintaining a relative stability of teams. By and large, those individuals who provided service in the 1968-69 programs have continued to do so up to the present time. When there has been similar stability in local Head Start staff, it has provided a reduction of anxiety on the part of local Head Start staff. Closer working relationships were developed with team participants; there was better understanding of each other's contributions and functions; and the quality of local programs was enhanced -- an achievement which cannot be expressed as "hard data."

Although since February, 1969, administrative changes took place in some local Head Start areas and community re-grouping altered some geographical patterns, we continued to provide the same number of twenty-three consultation teams for year-round programs. The list for 1969-1970 follows:

YEAR-ROUND HEAD START PROGRAMS (23 teams)

Southeastern Region
- Cape Cod (Barnstable, Bourne, Falmouth and Mid-Cape area)
- Fall River
- Boston
- Brockton Area (Brockton, Abington, E. Bridgewater, Mansfield, Holbrook, Stoughton, Whitman, Rockland, Easton, Canton, and Sharon)
- New Bedford
- Southern Middlesex County (Framingham, Ashland, Holliston, Hopkinton, Bellingham, and Natick)
- Taunton

Northeastern Region
- Cambridge
- Gloucester (Gloucester, Rockport, Essex, Ipswich, and Manchester)
- Lawrence (Lawrence, Methuen, Andover, and North Andover)
- Lowell (Lowell, Tewksbury, Dracut, Chelmsford, Tyngsboro, Dunstable, Westford, and Billerica)
- Lynn
- Communities United, Inc. (Waltham, Watertown, Arlington, Newton, and Brookline)
- EMOC (Malden-Somerville)
- Haverhill

Central District
- Montachusett (Leominster, Fitchburg, Ashburnham, Westminster, Gardner, Winchendon, Templeton, Baldwinsville, Athol, Lunenburg, and Townsend)
- Worcester

Western Region
- Franklin County - Orange
- Franklin County - Greenfield and Montague

Western Region (continued)
Holyoke and Chicopee
Springfield
Berkshire County (Pittsfield, North Adams, and Adams)
Hampshire County - Northampton area

In the summer of 1969, we continued with 41 teams to serve the following communities:

SUMMER HEAD START PROGRAMS (41 teams)

Ashburnham
Athol
Barnstable
Boston
Bourne
Cambridge
Chelsea-Revere
Chicopee
Eastern Middlesex (Malden-Somerville)
Fairhaven
Fall River-Freetown
Falmouth
Fitchburg-Leominster
Franklin County
Gardner
Gloucester
Hampshire County -- Ashfield
Hampshire County -- Northampton
Haverhill
Lawrence
Lowell
Lunenburg
Martha's Vineyard
Mashpee
New Bedford
Norton
Plainville
Quincy
Salem
School Union 1
South Shore -- Marshfield
South Shore -- Plymouth and Carver
Southbridge
Southern Berkshire
Southern Middlesex
Townsend
Wembroc
Westfield
Wilmington
Winchendon
Worcester

PEDIATRIC CONSULTANTS

Dr. Sprague Hazard, Chairman of the Massachusetts Chapter of the American Academy of Pediatrics, continued in his active support of the consultation program. During the time-interval reported, there were two changes in the chairmanship of the Chapter's Head Start Committee. Dr. Benjamin Sachs of Newton had replaced Dr. Allan Stimson of New Bedford in 1969, and subsequently he was replaced by Dr. Anthony V. Nigro of Reading who continues to the present time.

In addition to alerting the Head Start Committee Chairman to our problems relating to medical and/or pediatric practice, we rely on them to assist in locating pediatric consultant replacements as the need arises.

A total number of 42 pediatricians have served since our program began.

As a group, the pediatricians indicate that they would like earlier involvement in the consultation program. They wish that summer programs were extended to become year-round efforts. Many of them are interested in participating in regional meetings with the medical directors of local programs.

Although one of the goals of the Head Start Program is to have every child enter the medical care of a private practitioner, there recently appears to be regression in the achievement of this objective. This is due partly to the resistance of local practitioners to assume the care of these youngsters. Need still exists for a better interpretation of the program goals and problems to the members of the medical fraternity. Dr. Nigro attempted to bridge this gap by writing to each District Medical Society. However, pediatric consultants continue to underscore the need for further efforts in this area.

Some of the local programs have also felt the need for greater cooperation from their area mental health associations. Dr. Albert Frank, who is president of his area mental health association and a member of the Head Start Committee, requested that we draft such a letter for him to send state-wide.

In the discussion of technical matters, we note that several pediatricians suggest that local programs incorporate some type of developmental testing into health appraisal techniques. The Denver Developmental Screening Test is the one most frequently mentioned. Increasingly, also, pediatricians are beginning to mention the need for school participation, especially to make sure of follow-up from the summer programs. One pediatrician expressed her philosophy thus, "I would like to see the health aspects of project Head Start as a beginning of a permanent useful school health program."

PUBLIC HEALTH CONSULTANTS

Regional Health Office Staff continue to staff the consultation teams. They are appointed to serve by the Regional Health Officer who also makes replacements, if needed. Public health nurses continue to constitute the largest number of professionals involved. With the exception of the City of Fall River and Barnstable County, all staff are employees of the Massachusetts Department of Public Health.

The public health consultant continues to serve as the key contact person with local programs, and the initiator and coordinator of practically all activities on behalf of consultation. The public health consultant's in-depth process records and continuity of contacts constitutes the most extensive aspects of our program. A total of 32 public health staff have served as public health consultants.

Since each Regional Office staff has a specialist called the Day Care Coordinator, we attempt to channel inter-office directives and responsibilities via this individual. The Project Coordinator attempts to maintain liaison with the Day Care Unit of the Department by participating in the Unit's monthly Staff Meetings and other related activities.

In the Appendix, we have included some examples of different types of written communication which have taken place between Central Office and the public health consultants. Some of the memoranda indicate procedures while others were written to provide information about research, publications, and/or periodicals to help keep staff informed of recent developments in areas related to comprehensive child health programs. (See Appendix E through J.)

III. LIAISON ACTIVITIES

NATIONAL OFFICE

There is a constant need for improved communications and coordination in the Head Start program in part because although it is a relatively "new" program, it has been subject to an amazing number of changes in a short space of time. During the period of administrative transfer at the national level from the Office of Economic Opportunity to the newly-organized Office of Child Development, we experienced an inevitable hiatus of silence and lack of guidance from the national office.

It was, therefore, most helpful to have a field visit from Mr. Clint Mitchum in January, 1970. At this face-to-face conference it was possible for us to report developments in our program and learn about the organizational structure of the new Office of Child Development.

We reiterated that the original recommendations we listed at the time of our program report in February, 1969, were unchanged. We still feel that there is need for developing more effective channels of communication with regional and national OCD staff. We indicated that if Mr. Mitchum had a liaison responsibility with the American Academy of Pediatrics contract, we hoped that he would indicate to the Academy that we would like to be kept informed of any major procedural changes, for example, in the payment schedule.

We further indicated that we would prefer to have our pediatric consultants follow procedures identical with those developed by AAP. We raised the question of reporting -- to what regional office? Mr. Mitchum indicated that new relationships were to be established with the Boston OCD Office.

Dr. Gertrude Hunter, Director of Health Services, Project Head Start, has been very helpful to us when questions have arisen about procedures. We have discussed the need for better evaluation methodology and anticipate that she will call a work-conference to develop a national strategy.

In mid-February, 1970, at the request of Dr. Gertrude Hunter, the Massachusetts Project Coordinator was requested to participate in a conference to discuss accomplishments of our Massachusetts program with national staff. The purpose of the meeting was to assist in developing a valid mechanism for program evaluation at the national level. Although the meeting was held on March 6, our reactions and recommendations were based on program developments and experiences during the time interval contained in this Report. Therefore, it is appended. (See Appendix C.)

We participated in the four-day National Conference on Head Start and Child Development in Washington. (See Appendix D.) We attempted to share the information gained from this experience with our public health colleagues by circulating the Report and arranging a display of all the Head Start and Child Development materials made available to conferees. As a direct result

of this experience, our program attempted to emphasize the need for greater parental involvement.

REGIONAL OFFICE

We have been working very closely with the Regional Dental Consultant to monitor some of the local areas with many problems. We have kept him informed of changes and have begun to develop a more effective procedure to involve private dental practitioners in assisting local programs.

The Regional OCD Office invited us to attend a meeting of OCD Staff, RTO's and SEO's. With the establishment of the Office in Boston, this closer proximity has allowed us to communicate more freely with the Director, Mrs. Rheable Edwards, as well as the Supervisor of Field Representatives, Mr. Robert March. We stress the need for the Regional Community Representatives to make the personal acquaintance of the local public health consultants.

STATE OEO OFFICE

Our chief support and major source of technical information has continued to be from the state office. Since this office routinely reviews all project applications, they keep us informed about upcoming programs, lists of grantees, changes in addresses, names of Directors, enrollments, etc. We have developed a method of sharing all written general directives between our two offices by adding each other's names to our master mailing lists In addition, we use the telephone and have at least a monthly conference to keep each other up-dated and apprised of plans and developments.

THE REGIONAL TRAINING OFFICE

The Regional Training Office has provided us with current materials (in quantity for consultants) and involves us in training programs, as they are relevant. As an outgrowth of activity, we note that local Head Start Programs during orientation sessions or in-service programs are requesting assistance from the staff of the Regional Health Office, MDPH. Specifically, this has been reported from Worcester, Montachusett, Taunton, Framingham, Ashland, and Barnstable County. A reverse of this situation has also occurred. Head Start nurses have been participants of Massachusetts Department of Public Health regionally sponsored in-service training programs in the Northeastern and Western Regions.

IV. EVALUATION

GENERAL STATEMENT

A comment received from one of our pediatric consultants reflects the situation which continues to prevail in terms of the development of an instrument for evaluation which will satisfy the needs of all.

> "I guess I find myself still being a bureaucratic complainer. The Medical Consultant's Evaluation of Head Start Health Services (a form which I helped design for OEO) is almost completely inappropriate for a large city consulting programs. I have signed it and completed it and I doubt very much it is of particular help. I think that there is a great need for the consulting program in all big cities to be looked at separately from consulting programs in smaller communities."

Other portions of this Report indicate in a variety of different ways a composite of response to the judgments of our consultants as they made site visits. For purposes of amplification, we have requested and obtained CAP-HS Form 48 returns for both year-round and summer programs for two consecutive years -- the time period of this Report. Since we were included in the Bio-dynamics national study undertaken in 1968, we felt that we ought to compare the data for that program with the returns from the summer, 1969, program. This does not begin to include all the dimensions of all of our findings to date, but rather focuses on a "statistical sample."

The material which follows elaborates on the comparison between the returns for each of these years .... data from summer, 1968, serving as a baseline.

COMMENTARY ON ACCOMPANYING REPORT
"STATISTICS FROM MEDICAL CONSULTANT'S EVALUATION OF HEAD START HEALTH SERVICES (CAP-HS FORM 48) For the 1969 Summer Head Start Programs in Massachusetts"

(To adequately interpret the commentary which follows, it is necessary for the reviewer to turn to the appropriate table in the accompanying report to verify the observations made.)

INTRODUCTION:

The accompanying statistical Report records similar data tabulated for two consecutive summers, 1968 and 1969. The same evaluative criteria were used as a basis for reporting the results of each summer's program. Data was submitted by:

	1968	1969
Pediatricians	33	22
Generalists	35	26
	68	48

Although no cross tabulations have been compiled, visual review of the material reveals areas of differences between the experiences of 1969 in contrast with 1968. Differing observations and recommendations by pediatricians and public health generalists who served identical programs were recorded. Form CAP-HS 48 is based on a 3-point scale (i.e., very much so, adequate, inadequate, etc.) A 4-point scale would give a greater spread and perhaps indicate some refinement of the degree of differences in accomplishments between 1968 vs. 1969 as an upward or downward trend.

GENERAL OBSERVATIONS:

A review of responses to the following questions reflect program improvements in the areas specified. Replies to questions 2, 3, 4, 5, 9, 10, 11, 12a, and 12b indicate improvement over the programs of summer, 1968.

On question number 3 (Table 3.) which reads, "Did the PLAN for health services appear to be adequate to meet the health goals of Project Head Start?" we note a discrepancy between the responses of pediatricians and generalists. Pediatricians reflected observation of improvement while the generalists indicated a decline. The same situation prevails for question number 10 (Tables 9, 10 and 11) related to records of head start health programs. The first part of this question reads, "Was there a checklist, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?" Although it would seem that there either was or was not such documentation, pediatricians by and large reported that 91% of the programs did have such a record system while only 77% of the generalists so reported. This is in contrast to the fact that in 1968 the generalists reported that 91% of

the programs had such systems, while pediatricians reported only 85% of the local programs with such a system. It is difficult to explain the discrepancy between the responses of these two consultants. Where such a system existed, both pediatricians and generalists concurred in part 2 of question number 10 that the system accomplished its purpose; 95% of the pediatricians and 90% of the generalists so reported.

In response to question number 6 (Table 6), "Were parents present at the time of the physician's health evaluation?", it would appear that during 1968 parents were more apt to be present than during 1969 as recorded by the response to the item on "infrequently present."

In response to question number 7 (Table 7), "Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components?", it would appear that the programs in 1969 were slightly less efficient. We find the same downward trend holding in response to question number 8 (Table 8), "Was the health program planned and organized so that children could obtain continuing care from the physician examining and treating him in Head Start?"

Question number 12 (Tables 12, 13, 14, 15, and 16) is subdivided into five parts, and it relates to a summary evaluation of head start health programs. It appears that the overall degree of success in achieving specified goals is not consistently up or down between the two summer programs. Responses to that part of 12, which reads "How well did this program succeed in achieving each of the health goals listed below?" namely, "(a) Finding health defects and (b) Treating health defects" reflect <u>improvement</u> over achievements of the summer of 1968.

In response to question number 12c, how well this program succeeds in "Preventing future health problems," the responses indicate that the degree of success has decreased in the specific areas of immunizations, fluoride dental treatment, health education, introducing the child to the physician who can provide future care, and introducing a child to the dentist to provide future care. Generally, the same consultants served both years. Therefore, we might assume that in the second "go around" they were more critical of goal achievements; and since there was no marked change, programs were rated downward. The same situation holds for question number 12d, "How well did this program succeed in improving the health of family members by calling attention to family health needs or introducing the family to sources of health care funds and services?" Responses were quite contradictory to question number 12e, "How well did this program succeed in achieving improving the health of the community through increasing awareness of health problems of poor children; stimulating new resources to provide and care for child health care; and making existing resources more responsive to the special needs of the poor." Responses to the first item reflect improvement; the second item, less success; and finally, in the third item, the public health generalists note distinct improvements over last year while pediatricians indicate no change.

In response to question number 13 (Table 17) on the impact of the Head Start Health Program, "To what extent did the Head Start Health Program provide services which these children would not have obtained (or would have obtained only after significant delay) without Head Start?", there are discrepancies between the two classes of respondents. Pediatricians and generalists evaluated the following items completely differently: screening tests, medical history and examination, and medical treatment. By and large, the generalists felt that these three categories showed improvement while the pediatricians' responses indicated poorer performance. In the area of dental treatment and immunization, there was greater agreement between pediatric and generalist respondent, both programs reflecting poorer performance in these categories over 1968.

In response to question number 14 (Table 18) on the consultation process, the data are clear cut. However, we might point out that generalists in 1969 in contrast to 1968 were more involved in meetings with head start parents and visiting head start classrooms in action. Pediatricians responded they were more active in visiting head start classrooms and "meeting with the community action agency director or his representative." One recorded figure is still highly significant: only 14% of the pediatricians report meeting with the local medical society or its officers.

In response to question number 15 (Table 19) on the consultation process, namely, "In which of the following ways were you able as a consultant to help?", looking at the overall data, there seems to be a centering trend under "minor impact." Both pediatricians and generalists are fairly consistent in similar response to the five categories listed under this question.

In response to the final question number 17 (Table 20), we note that in 1968 the majority of generalists responded by checking the item that "The program was worthwhile if modified," and then proceeded to make comment. During 1969 there was a change in this category. There was an increase in the number of respondents who made no comment and indicated that the program was "Worthwhile and should be continued." Of the three pediatricians who indicated that the program was "not worthwhile and should not be continued," they made the comment that it was because they would like to have the program expanded or extended beyond a summer program. In other words, they were actually saying that head start programming is worthwhile.

IN SUMMARY:

Generalizing on the foregoing, we can record that there was a consensus about "less success" in 1969 than in 1968 in achieving immunizations, fluoride dental treatments and health education programs. Also, fewer families were introduced to a physician or a dentist who might provide future care.

Distinct health services improvements were indicated in the following categories:

1. *Planning involved more meaningful participation, and was more adequate.*

2. *Programs were well carried out and showed improvements in informing physicians of goals.*

3. *Records were of sufficient detail and quality and were systematized to insure follow-up and a base for future planning.*

4. *There was greater success in finding health defects and in treating them.*

*ANALYSIS OF RESPONSES TO SUGGESTED MODIFICATIONS**

Suggestion	Reports Submitted By: Pediatricians	Generalists
Earlier involvement	5	4
In funding the program		
For orientation of new staff		
For pre-admission examination of children		
For evaluation		
For involvement		
Expand or convert program into a year-round effort	9	3
Orient Head Start staff to health program goals	-	1
Clarify the role of physician	-	1
Medical Director vs. Pediatricians		
Provide continuity	1	1
By meeting with next year's school staff		
Retaining present staff		
Provide adequate funding for staff nurse and physician	-	1
Recommend regional meetings for project staff and medical consultants	1	-
No suggested modifications	9	16

*Some respondents provided more than one suggested modification.

Consultant Contributions

(As reported by public health generalists and pediatric consultants serving the same programs.)

KEY: 1. is the response of the pediatrician.
2. is the response of the generalist.

Community A

1. *"Discussed and decided on way to get action in case of psychologic school problem. Five-year-old, overactive, on tranquilizers, 'didn't eat.' Parents alcoholic, mother in and out of state mental institution. Suggested we work to help youngster by attacking home problem through social service dept. of State Hospital. They, undoubtedly, would get father removed from scene. His visits are disruptive. Just giving this neurotic youngster better looking and tasting food will not change him. His weight and height chart show his development in these areas is normal, in any extent. The fragmented care here needed to be better organized."*
2. *No comment.*

Community B

1. *No evaluation received.*
2. *"Suggested that University of Massachusetts be contacted about the possibility of sending students majoring in speech therapy to work with school speech therapist as a field experience. This program has many children with speech problems who have not received any help to date."*

Community C

1. *No comment.*
2. *No evaluation received.*

Community D

1. *No evaluation received.*
2. *"Unable to arrange for pediatric consultant to attend review session, (illness and absence, etc). Review done jointly with Director, nurse and case aide: productive discussion of procedure, but not of overall medical policy and direction based on Headstart changes."*

Community E

1. *"Recommendation re: most expeditious way to secure emergency medical services."*
2. *"Introduction of Health Services Bookkeeping System. This program had 2 plans to accomplish the medical and dental examinations. Plan I consisted of all plans, appts, etc. being made by Headstart nurse through the local hospital and Boston University Dental Clinic. Plan II was that parents elected to have medical and dental exams by physicians and dentists of their choice. Immunizations and other screening procedures were not routinely done. Statistics submitted, by and large, are for those children in Plan I. Children under Plan II have appts. that were scheduled long after the close of the Head start Program."*

Community F

1. *"I called to the attention of the planning group - the existing facilities for doing blood work up - the use of the Tuberculosis Society to do Tine Test - the Society for the Blind to do eye testing."*
2. *"This is a well planned and coordinated program and has been for past two summers. Have assisted with record keeping this year and also follow-up visits by aide."*

Community G

1. *"I don't think that I contributed much of value for this year's program because the program was nearly over when evaluation was made. The head start director did a very adequate job with the limited time and facilities available."*
2. *"Since the Health Services Program was having great difficulty in imparting the need for dental care in young children to parents, consultant brought in Dental Hygienist for screening program and discussion with parents."*

Community H

1. *"There has been a large number of children in the Summer Program who are repeats and I fail to see why this is necessary. A year-round program would eliminate this."*
2. *No evaluation received.*

Community I

1. *"From this consultant's viewpoint the 1969 Medical Program of the _____ _____ Summer Head Start Program was disappointing. The major difficulties seemed to be lack of time available for planning both the entire program and particularly the medical aspects. This made it impossible to carry out any of the recommendations made in my report of the 1968 summer program visited in Sept. 6, 1968. Because of the short time available to get the program started, largely due to short notice of available funding for the program, the medical director was not consulted and other agencies were not contacted. Many of the physical examinations and dental examinations were late and not completed at the time of my visit on Aug. 5, 1969. Despite these shortcomings, some aspects of the medical program seemed to run smoothly thanks largely to the diligence and energetic efforts of the project nurse and the ancillary help she was able to muster. My main function seemed to be to give the project nurse some support and direction in her efforts so that her time was perhaps more effectively spent. That the Community Action team can plan and effectively organize a very satisfactory medical report is obvious at this delayed reporting by comparing the progress already made in the present year-round Headstart Program. At this writing the Community Action Agency has decided to discontinue the summer program and concentrate on year-round programs. Medically this seems a wise decision with gratifying progress as noted above."*
2. *"Gave consultation and support to the Head Start nurse who was new to the program."*

Community J

1. *"During the evaluation visit the project director, nurse and social worker were the only individuals present. The representative from the granting agency had been present at the project meeting (visited on the same day). Accordingly, there was a chance to indicate similar needs for this particular delegate agency as well. The matter of planning and completion of the health work-up prior to the beginning of the program was finally stressed at this Center, as well. An offer was made by this consultant to participate in future planning pending the agreement of the Policy Advisory Council and the medical director of the project. The remarkable accomplishment in the health program at this Center is more related to the dedicated zeal and skill of the nurse and the social worker rather than as a result of planning. Their very effective community work - in dealing with the families of Head Start children and bringing in a variety of agencies not only to help the children but also the families of children approached some of the real goals of Head Start. This aspect is without criticism - on the other hand, more opportunity in some of the medical follow-up needs might have occurred if more effective planning assignment and commitment had taken place during the Spring."*
2. *"Since the head start director, nurse and social worker were new to the program it was necessary to channel them to the many agencies which were beneficial in carrying out a well-organized use of the resources in the area; namely a psychometrist, Catholic Charities, Mental Health worker, B.P.W., local B of H., Lions Club, Red Cross, Salvation Army and a school adjustment counsellor."*

Community K

1. *No comment.*
2. *"Physical examinations were given by local pediatrician. Program provided on Title I monies."*

Community L

1. *No evaluation received.*
2. *"I organized a fairly successful meeting of the health team at the close of the program. Through this meeting the team evaluated the summer program. Hopefully these findings will be applied to future programs."*

Community M

1. *"Apparently the Head Start people were presented with what amounted to an ultimatum that they were to complete a dental evaluation despite the fact that it was made clear to their superiors that the local resources for dental evaluation and the funds available made it impossible to do this. This does not provide these well motivated and intelligent local Head Start workers with the support, encouragement and motivation that they need. Demands should be consistent with resources available."*
2. *"Late funding and insufficient monies to allow for a Medical Director of Health Services and to provide for adequate nursing time limited the functions of the consultant team to making recommendations that it was impossible for the staff of the Headstart program to accomplish."*

Community N

1. *"Nutritional follow up, vitamin and fluorides as well as food per se. Vision testing ——→ follow up of results and treatment."*
2. *"Suggested more complete follow-up to assure defects are corrected. The present procedure seems to end once the parent is notified, however the health staff is never sure of the final status of the correctable defects. Need better working relationship with Board of Health nurses."*

Community O

1. *No evaluation received.*
2. *"A meeting with Mental Health agent and School Principal resulted in an asmatic youngster being changed from being enrolled in A.M. school session for coming semester to P.M. session. Dr. _____ spoke with group of parents of children enrolled in the program. Parent Participation very good. Program well organized."*

Community P-

1. *"Suggested that immunization, physical exam, lab and screening test be done at same time & place c̄ mother present. Urged that schools require lab and physical exam as done by H.S. M.D. so more assurance of follow up possible."*
2. *"In early planning stage of 1969 program, based on poor response of medical interest in 1968 program, suggested surveying physicians and dentists to see if they were interested in participating. The response was neglible. As a result a plan devised for children to be examined in respective classrooms by physicians employed by Head Start. Local hospitals provided free laboratory tests."*

Community Q

1. *"I re-emphasize the desirability of having a part-time Medical and Dental Director. A dentist contact should be established at once to do the surveys and plan a program for fluoridation either oral, topical or both."*
2. *No evaluation received.*

Community R

1. *"Due to the Summer program limitation I have to admit that the entire summer schedule is most inadequate and wasted. A year-round program without summer interruption would be highly desirable. I have made such recommendation in previous reports and personal letters."*
2. *"Suggested possible future use of Dental Hygienist since dental treatment was a problem area."*

Community S

1. *"Suggested evaluating the Denver Screening Test for incorporation in future programs, as provided by Mead Johnson Company, at no cost, via the Academy of Pediatrics. Suggested interpretation of County Medical and Dental Societies in order to promote local physicians cooperation, well in advance of next year's program."*
2. *"Suggested training and use of health aides for vision and hearing screening programs."*

Community T

1. *"Services were offered by this consultant to assist with planning and indoctrination."*
2. *"Arranged at the suggestion of the pediatric consultant, to have present at the final evaluation, members of the Advisory Board, to stress the importance of early participation in planning for the Health Services program for all Head Starts."*

Community U

1. *No evaluation received.*
2. *"The grantee proposed to pay two local dentists to do dental screening of all the enrollees. I arranged for the dental hygienist from the regional office to conduct this screening to eliminate the use of the skilled practitioner."*

Community V

1. *"I honestly do not feel that I contributed anything. The program had been running well for several years without any consultant. I did submit my suggestions for the 1970 program."*
2. *"Telephone calls were made to Head start Director and dates for two meetings were set up. Serviced Dental Hygienist with dental health educational materials and had conferences with her regarding her participation in Head start Program."*

Community W

1. *"Evaluation of health aspects of medical program - screening and immunizations. Attempt to co-ordinate a "total" approach to program -- integrate group, family, child. Attempt to get more parent involvement in program. Help to search for psychiatrist to implement program. (Not successful as yet.)"*
2. *No evaluation received.*

Community X

1. *"_____ and environs is an area possessing inadequate health facilities. Obtaining services other than a routine physical examination is rather difficult and in some respects not possible without the availability of some equivalent to a mobile unit. The director and his staff are continually frustrated by this void -- and they have extracted the maximum of what facilities they possess in the absence of these facilities. The need for a full time health supervisor (nurse or other qualified individual) is imperative and should be allowed in their funding. One example of the inadequacy is that there is no one available who is qualified to interpret the reports submitted by the few general practitioners. Thus they have no means of identifying many of the defects that need attention and follow-up. I strongly urge, again, that they be allowed to fund for a full time health supervisor."*
2. *"Much of my contribution this year was a reiteration of previous recommendations and strong urging of greater nursing participation and coordination of nursing and social work services."*

Community Y

1. *"This is a well established organization which has worked out many of the important agenda and communications in the community necessary for an effective health program. They have established techniques for involving certain agencies and are aware of those which cannot be budged. Furthermore, they are in a constant posture of negotiation and advancement with respect to increasing the involvement and commitment of agencies directed towards helping Head Start children and their families. The social worker and nurse were very effective in gaining the cooperation and participation of the VNA and the Board of Health in _____, both not particularly helpful in previous years. These two workers were also instrumental in using the class setting in sorting out disturbed children, arranging for studies and referral. Finally, the rewarding experience gained in this summer program by health, social and educational staff as well as the community agencies and the children brought out the need for a year-round program. The plan is to divert such financial resources as were used in the summer program into a year round program. Accordingly, the summer program will be discontinued."*
2. *"Suggested that they meet with V.N.A. and Board of Health Nurses in order to better coordinate and provide services to head start families. Headstart agency did follow through and have set up good working relationship with both groups."*

Community Z

1. *No evaluation received.*
2. *"This was a normal group of children as a whole very good. There were no physical or mental problems. This year the program was well organized, clearer, better understood. Individual training better than the week of orientation. Parent Participation very good. Director's comments: The program was excellent."*

Community AA

1. *No evaluation received.*
2. *"Was able to assist newly assigned nurse-coordinator for active participation in orientation program for all staff particularly in relation to: (1) Increasing respect for role of teacher in maintaining or improving health of child. (2) Helping staff to see 'health' in the broad sense and affecting the development and 'learning' ability of child. (3) Stressing preventive pediatric health measures applicable in daily life of child, particularly accident prevention."*

Community BB

1. *No evaluation received.*
2. *"This program started out fairly well at the planning stage but seemed to fall apart health wise as time progressed. I believe this was due to the nurse in the program who was new, not public health oriented, never seemed to get going. Feelings between nurse and social work aide did not lend to cooperation. My suggestions at the planning session were not considered. At final session of team meeting gaps in health program were obvious. Consultant provided assistance in securing nutritionist to talk with parents."*

Community CC

1. *No evaluation received.*
2. *No comment.*

Community DD

1. *"1. Promoted idea of continuing treatment to the head start program director. 2. Furnished good forms for history and physical as base line for future care. 3. Spoke to class teachers, advised 'draw a person' test etc which was helpful. 4. Stimulated director to get most of the exams done by family Dr's."*
2. *"Urged Director to provide some kind of 'follow-through' since the nurse was not a school nurse."*

Community EE

1. *"The most important recommendation that I can make is that a Medical Director be appointed to direct and coordinate all medical aspects of the year round program. It would seem best that he or she should not be an employee of the city or School Health department. One of the major objectives of the Medical Director would be to involve local physicians as advisors, direct participants or participants through Medicaid services."*
2. *No evaluation received.*

V. TRENDS

In our activities we are experiencing closer liaison and involvement with other types of community programs for preschoolers such as Day Care and 4-C's. Head Start achievements are influencing them to consider the establishment of health guidelines or requirements for their respective programs, or to develop community resources which will provide them. This includes stimulation of local health departments and/or hospital and pediatric clinics to begin to think about providing service.

Head Start Directors are beginning to ask questions about their "poverty segregated classrooms," and some are taking necessary steps to expand and include children from "other than poor" programs.

Where delegation of Head Start programs is to local school departments, health programs tend to follow the established pattern of [illegible] given school systems. Often this is at variance with Head Start Guidelines. One area of exception and a break with traditional approaches has been the acceptance of the concept of parent involvement. Many school administrators show a willingness to plan programs resulting in extensive parent participation with adult education taking place successfully side-by-side with early childhood education. These activities have centered on developing an understanding by parents of what is taking place in their children's daily experiences, rather than on soliciting their involvement in policy or decision making.

There is increased community awareness of the goals and needs of local Head Start Programs. An example is concern for locating physical facilities which meet mimimum local safety and wiring standards in order to qualify for licensing as a day care facility under Massachusetts statute.

VI. RECOMMENDATIONS

1. Require end-of-program statistical reporting on health services. This report to be shared with all who have a responsibility and/or a concern for quality. It is one measure for gauging program's effectiveness as well as revealing strengths and weaknesses. (See Appendix A and B.)

2. Require that the local Head Start project application spell out how recommended health services will be provided, including documentation to insure that professionally qualified specialists, nurses, physicians, dentists, and psychologists are employed to assume professional responsibilities. Require that the direction of health services (requiring medical judgments) should be under a designated physician, even if only on a consultant level.

3. Improve the dental program by greater surveillance of on-going activities and greater assistance in locating man power to provide treatment, both preventive and therapeutic, (including application of topical fluoride) and to encourage broad spectrum dental health education, including education about fluoridation of municipal water supplies.

4. Establish a mechanism to insure that "consultant teams" are invited to participate early in program planning, and to review project applications before funding. (This will require more cooperation from Regional Community Representatives.)

5. Clarify the respective roles of employees in the social services program and in the health services program so that their efforts will be coordinated at the community level.

6. Develop a training program with the OCD Regional Training Office on Child Development and Health Services relating to the problems and resources in Massachusetts.

VII. APPENDIX

Selected materials developed for use in the Consultation Program

Statistical Data - Health Services in a Head Start Program	A
Health Program Class Register	B
Some Considerations in Developing Instruments and a Methodology to Evaluate the Impact of Head Start Health Services Programs	C
Report on the 1969 National Conference on Head Start and Child Development	D
Letter of Assignment to Pediatricians	E
Memorandum Re: Reporting on Summer Head Start Programs	F
Memorandum Re: CAP-HS Form 48	G
Memorandum Re: Head Start News	H
Memorandum Re: Recent Materials Related to Head Start Prcgrams	I
Memorandum of February 4, 1970	J

VIII. ATTACHMENTS

Report on Program of Medical and Public Health Consultation to Project Head Start in Massachusetts, February, 1969

Statistics from Medical Consultant's Evaluation of Head Start Health Services (CAP-HS Form 48) for the 1969 Summer Head Start Programs in Massachusetts

Statistical Data - Health Services in a Head Start Program

Date Report Submitted: _____
Name of Program: _____
Type (Year Round or Summer): _____
Date Program Began: _____
Date Program Ended: _____

TOTAL PUPILS ENROLLED: _____

I SCREENING PROGRAMS	Completed No.	%	By Whom Done (Specify)	No. Not Completed	Positive Findings No.	%	No. who completed referrals for further evaluation or T.
Health Appraisal							
Lab.-Urinalysis							
-Hematocrit or Hemo.							
Vision							
Hearing							
T.B. Testing							
Psychological							
Speech							
Dental							
Other							

II IMMUNIZATIONS	Completed PRIOR to Head Start No.	%	By whom:*	Completed DURING Head Start No.	%	By whom:*	Total Completed	NOT COMPLETED to date No.	%
Small pox vaccination									
D.P.T. (initial series)									
D.P.T. Booster #1									
Booster #2									
Polio Initial									
Boosters									
Measles									
Other (Specify)									

III Referrals Made as Result of Head Start (other than above)

	No. Made	No. Completed
Mental Health Association		
Family Service		
Other		

*Designate by Private M.D., Clinic, etc.

7/68 -- 250

COMMENTS ON ABOVE (If more space is needed, use reverse side.)

Appendix A

HEALTH PROGRAM CLASS REGISTER

Head Start Center | Class | Year

NAME	IMMUNIZATIONS				TESTS					Dental evaluation	Medical Evaluation	Other as Needed
	DPT	Polio	Small pox	Measles	Vision	Hearing	Hematocrit Hemogl.	T.B	Urinalysis			

The following code for recording is suggested:

___	Space is to be left blank until evaluation or test is performed.
O K	If evaluation or test has been performed and no referral required enter OK in the spaces.
R ___	If evaluation or test has been performed and referral for treatment required enter an R in the first space in the column.
R C	When treatment has been given and no further remedial action--enter a C opposite the R.

6/14/68 - 100

30

Appendix B

CODING EXAMPLES:

	TESTS					MEDICAL EVALUATION	DENTAL EVALUATION	D.P.T.
	TUBERCULIN	HEMATOCRIT HEMOGLOBIN	HEARING TEST	VISION TEST	URINALYSIS			
1.	OK	OK	OK	OK	OK			

All screening tests have been performed and found to be normal. Child is ready for medical evaluation.

2.	A	OK	OK	OK	OK								

Tuberculin test was performed and found to be positive. Child needs further evaluation.

3.	OK	OK		OK	OK								

Child was absent on day of hearing test. Reschedule test.

4.	OK	OK	OK	OK	R	C							

Abnormal urine test has been rechecked twice and found to be normal.

5.	OK	OK	OK	A	C	OK							

Abnormal vision screening test. Child has seen eye doctor and is wearing glasses.

6.	OK	OK	OK	OK	OK	OK	R	C					

Child was found to need to have two teeth filled. This was completed immediately and no further care is needed.

7.	OK	OK	OK	OK	OK							C	K

Child has had three DPT shots, the most recent a few months ago. He is "completely" immunized for DPT, requires no further shots.

8.	OK	OK	OK	OK	OK							R	C

Child had two doses of DPT in infancy. He was given third dose at time of Head Start interview and is now "completely" immunized.

9.	OK	OK	OK	OK	OK							R	

Child never previously immunized received one dose of DPT at time of interview, needs another before end of program.

10.	OK	OK	OK	OK	OK								

Immunization status is unknown; mother should be interviewed and any past health records examined.

Appendix C

1st DRAFT -- March 20, 1970

SOME CONSIDERATIONS IN DEVELOPING INSTRUMENTS AND A METHODOLOGY TO EVALUATE THE IMPACT OF HEAD START HEALTH SERVICES PROGRAMS

Submitted by: Hedwig M. Sorli
Project Coordinator
Massachusetts Head Start Health Services
Consultation Program

Procedural Steps

1. Ascertain what is significant baseline data available from the summaries of the studies which have been completed from 1965 to date. (Census studies, national studies of CAP-HS Form 64 and CAP-HS Form 48.)

2. Define the goals of Head Start Health Services in precise terminology. (These goals should have some congruence with the over-all goals of the entire Head Start Program. For example, at the present time, the National Office is emphasizing the expenditure of time and money in the career development areas. There is a real question of whether leadership characteristics of those competent to handle programs for children will, in fact, suffice to carry on programs which are essentially in the area of adult education. What are the responsibilities of health services staff in the area of career development?)

Miscellaneous Problem Areas

1. If Head Start is defined as one type of day care program, should there be some relationships between other community day care programs and the local Head Start Program in terms of comprehensive health care?

2. Does the health services program inaugurated in Head Start bear some relationship to the school health program in the local community? What methods are used to assure continuity of record-keeping between the two programs? Would a cohort study of children who graduate from Head Start into Follow-Through Programs yield some significant data about the quality of health services?

3. Would the establishment of written standards for health appraisal procedures yield more valid firm data about the health status of children? For example, for hearing screening, would it not be possible to state that a discrete frequency audiometer must be set at definite levels?

4. Would it be possible to measure the impact on health services of a lack of minimum personnel to man a program? For example, is a program without a medical director less or more effective in providing services to children? When there is no medical director available to a program, who makes medical decisions? In programs employing dental hygienists, who gives the dental hygienist directions? Is it necessary to have a dental advisor? When the Head Start budget does not allocate sufficient funds for the employment of competent personnel, is it possible to measure the effects of such deficiency?

5. What kind of performance impact does the availability of technical consultation provide? Are there measures to determine the effectiveness of a training and/or consultation program on nursing, medical or technical areas to promote greater efficiency in performance? What are the measureable effects of the availability of a multi-disciplinary team on health services effectiveness? Does full utilization of all community resources available in the health areas strengthen programs? What impact does it have on the health status of the enrollees? Is it possible to develop measures for determining the impact of pre-service and in-service training programs on Head Start staff and their functioning (nurses, health aides, teachers, etc.)?

6. Does a clear definition of role and responsibility of staff working on health programs insure greater effectiveness? For example, what is the role of the medical director vs. the role of the pediatric consultant? Are there measures to determine the most effective ways to communicate with the medical and dental community to increase understanding of Head Start program goals and to encourage medical and dental cooperation in the care of children referred?

7. Can measures be developed to insure effective record-keeping and utilization? Would these records reveal significant prevalence data?

8. Which are the most effective methods of parent training and counselling -- group methods or individual methods?

9. An increasing number of children are receiving private examinations in the physicians' offices under the Medicaid program. Is there any way to measure or to document the criticism of many low income parents about the quality of this examination for their children? Is it more important for a program to have 100% of the enrollees given a physical examination by whatever means, or is it more important for 75% of the families to be motivated to seek out this kind of care for their children on their own initiative?

Appendix D

REPORT on

THE 1969 NATIONAL CONFERENCE ON HEAD START AND CHILD DEVELOPMENT

Sheraton Park Hotel
Washington, D.C.

December 14-18, 1969

Submitted by: Hedwig M. Sorli
Head Start Health Services Consultation
Project Coordinator

Advance publicity for this National Conference on Head Start and Child Development indicated that its purpose was to explore new initiatives in the Child Development Program of HEW. An estimated 1200 people were invited to attend the workshop and discussion meetings from the Northeastern, Mid-Atlantic and Mid-Western States. The delegates included local Head Start Directors, Policy Advisory Council Chairmen, representatives of State Health, Education, and Welfare Departments and a large delegation of representatives of parents' advisory groups. The details of programming and staffing and the physical arrangements for the conference were very well handled. Each delegate, on registering, was given a packet of new material which it would take a week to read and which apparently most conferees took home for perusal. This material we hope to share with our public health colleagues who are involved at the local community level with Head Start Programs. The official program indicated that speakers would examine new directions and policies of the recently established HEW Office of Child Development (of which Head Start is a part.) Formal presentations were made at general sessions and small group discussions followed thereafter, so that all might participate.

The first general session was scheduled to have a presentation by Jule Sugarman, Acting Director of the Office of Child Development, on "By-lines and Directions." When I checked into the hotel on Sunday, I saw signs all over the lobby indicating that National Head Start Parents Involvement Day was to be Monday, December 15th. When the conferees assembled at 9 o'clock on Monday, the 15th, they discovered that instead of an address by Jule Sugarman, a so-called Parent Participation Group had taken over the program; and we became participants in a confrontation of essentially black parents. Although their resolution began with a mild declaration which read, "We, the parents of this delegation of the so-called 'Silent Majority' feel strongly that the Head Start By-Lines on Meaningful Parents Participation should be enforced on the Federal Level as demanded of us by OEO." It became increasingly evident as speaker followed speaker that the meeting was an opportunity for individuals to vent their hostilities and their frustrations.

Reviewing my notes I find statements such as the following: "We know our own needs." "We need a national parents' policy board." "There is no other way for our parents group to talk to national staff except right here - right now." "Head Start programs are not representative." "Politicians use us just to keep parents down so that they can be in control." Statements

by one delegate that "The official HEW policy will be that the entire Head Start Program will be delegated in such a way that the parents will have control and that the parents' role shall be policy-making rather than policy-advisory," indicates the tenor of parents' views.

It was the desire of this group to seek to establish a national Parents' Policy Board to make decisions pertaining to Head Start funding, parent control, program guidelines and policies. In amplifying on this idea, members of the audience expanded from the subject of Head Start to all Federal programs in the public schools indicating that they felt that all Federal programs in the public schools should be required to adopt and adhere to the philosophy of "Parent Control". They further indicated that their feeling was that the National Offices should not continue to fund training programs in institutions that are hostile to the philosophy of "Parent Control". The group was so distrustful of the conference plan that they voted to dispense with small group discussions for the first day and instead discuss their grievances together in the large assembly hall. Certainly the ventilation of so much frustration and the desire for change will give the national as well as the local program directors much food for thought about changing program directions.

Another area with which dissatisfaction was expressed was that of career development programs. Conferees expressed real hostility about professional roles and great misunderstanding of these roles. It was apparent that many parents employed in local programs or in training programs felt that they have gotten nowhere up the career ladder. They were hung-up on financing, on jobs, and on tight money. If they were asked to act as consultants to local programs, they wanted to be paid to be consultants.

As a matter of fact, I found that there was a regular vocabulary used over and over again and that it had different meanings for different people. The words that kept getting reiterated were "professional vs. non-professional," "power," "control," "advisory vs. control on rights and powers of parents advisory committees." In short, it would appear that there might be development and reorganization of parents' organization from the local, to the state, to the regional, to the national level, as a consequence of this conference.

State HEW and SEOO Conferees had the opportunity to meet in two sessions. Jule Sugarman addressed one of these sessions. We were also able to meet as a "state group for discussion of the 4-C Program; and as a "regional group" to meet with the new OCD Director of the Boston Office and her staff.

Although most of the debate and discussion of this conference centered around parental roles and career development of adults, there was some emphasis on the children enrolled in Head Start through concept sessions. In these, experimental programs were discussed in some detail. I was interested in experimental programs, principally in the health area, and heard the presentation by staff of the Detroit, Michigan, Head Start Program who discussed utilization of the community health worker, and also the Head Start Director of Holly Springs, Mississippi, who described how vouchers were used in a county Head Start Health Program.

An excellent exhibit area was set up at the hotel, and a continuous showing of films suitable for Head Start Child Development Programs were previewed. It was possible to informally talk with people from many different parts of the country, professionals as well as parents, while coming and going in the hotel. The extent of emotional commitment to the program by parent delegates was especially impressive. They had a total concern for all aspects of the program and had become involved enough to feel that no programming should take place without their participation.

Conferees not only heard new legislation reviewed, but Julie Sparman in his final presentation, very effectively tried to broaden the horizon of all who had been concerned about only Head Start into the total area of child care, of day care, and of the development of the 4-C Program at the local community level. Conferees were alerted to upcoming legislation on which the Congress must act; specifically, there was constant reference to the Brademas Bill. It had been anticipated that copies of this bill would be made available to participants, but it was not possible to do so in the four-day period. Among significant new materials made available to conferees was a digest of "Crisis in Mental Health; Challenge for the 1970's." This is the summary of the final report of the Joint Commission on Mental Health of Children, Inc. printed in the fall of 1969. Additional materials made available included recent additions to the Rainbow Series, including Volume 10a which relates to Parent Involvement in Project Head Start. The conferees were presented with policy statements. One of them from Richard Orton, Project Head Start Director, was on the Interim Career Development Policy. Another one, which was used as a discussion paper, related to the Administration of the Local Head Start Program and the possibility of a new look at the roles of various groups and individuals who have the responsibility of administering the program. In addition, we ordered a summary of research findings.

One speaker said, "Head Start is not a job, it is total commitment." Although the basic focus of this four-day program was on Head Start and the need for program revisions and expansion, my general impression was that in the area of child care and child development, the trend will be to broaden services at the community level rather than to restrict them and that the future holds the opportunity for all organizations with a concern for early childhood education, to work together to develop a coordinated approach and a plan for all children in each community or region in the country.

Aside from the process of information-gathering at this conference, I found it particularly rewarding to talk to and meet many individuals. I had the opportunity for the first time to meet many of the local Head Start directors of our Massachusetts Programs, to participate with other representatives from our Regional Offices in the discussion of regional programming, to have a conference with Mrs. Peters who is the chairman of the State Parent Advisory Committee, and to meet Dr. Harrison of Howard University, who is currently under contract with Bio-Dynamics, to prepare health education material for Head Start Programs. Most especially, it was worthwhile to attend with a colleague, Miss Frances Heald. While Fran and I responded differently to different program facets, together we had the opportunity to share immediately our own reactions. Hopefully we plan to bring to staff who have a concern for Day Care, some input on developments at the national level, which may significantly influence our local program efforts.

Appendix E

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

June 12, 1969

The Massachusetts Head Start Health Services Consultation Program will continue to provide team consultation to the same community Summer Head Start Programs in 1969 as were funded last summer.

The Head Start Committee of the Massachusetts Chapter of the American Academy of Pediatrics and our Department are not anticipating changes in the consultation procedure for these programs at present. When the National Office of Child Development is established and other directives apply, we will keep you informed of developments relating to Head Start.

For the up-coming summer programs, we are endeavoring to maintain continuity with the same consultants who served during Summer, 1968. Unless we hear from you to the contrary, may we assume that you are still interested in participating as a pediatric consultant. (We would appreciate your return of the enclosed postal card indicating any change of your availability.) Unless there is contra-indication, the team Public Health Consultant will contact you to make the arrangements for consultant visitation.

Our Contract authorizes at least two consultation visits for summer programs, one for program review and planning and one for evaluation at the close of the program. The reimbursement procedures remain the same, as described in the enclosed explanatory letter of 7/68. Copies of the Pediatric Consultant's Report Form and the Payment Voucher Form are also enclosed. As you may recall, it is necessary to complete and forward signed copies of <u>both</u> forms after a site visit before we can process payment vouchers.

We appreciate your continued cooperation.

Sincerely yours,

M Grace Hussey

M. GRACE HUSSEY, M.D.
Project Director

MGH/ab
Encs: postal card
Letter of 7/68
3 Ped. Cons. Reports
3 Payment Vouchers

Appendix F

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

MEMORANDUM

To: Public Health Consultants (Generalists)
Program Head Start Health Services Consultation

From: Hedwig Sorli, Coordinator

Date: July 25, 1969

Subject: Reporting on Summer Head Start Programs

I The procedure for reporting consultation contacts, site visits, etc. remains identical with that established in 1968. Since we were able to compile some base-line data last year, we hope to correlate it with the continuing input you are able to provide on the program. (Pediatric consultants are also continuing their site visit reports.)

We quote from the guidelines of 1968:

> "Please, record every activity in behalf of your program on the enclosed form entitled, Public Health Generalist's Report. We hope this will be an easy way to indicate the extent and type of service unique to Team Consultation for the final Project report.
>
> "PLEASE, SEND THE CARBON COPY OF EACH REPORT to us here in the Division."

II The Evaluation Form (CAP-HS Form 48) will be sent out next week. We hope that it will be possible for each consultant (pediatric and public health) to complete this form at the close of each summer program.

III We are also attaching copies of the sheet, "Health Program Class Register," (adapted from the Health Services Bookkeeping material). The nurses and directors of local Head Start programs have found it a useful form for "seeing at a glance" what has been done and the need for further action. (We have a supply of these sheets which you may order.)

HMS/ab
Encs.

appendix G

The Commonwealth of Massachusetts
Department of Public Health
Division of Maternal and Child Health Services
88 Broad Street, Boston 02110

MEMORANDUM

To: Pediatric Consultants and Public Health Consultants for Head Start Summer Programs

From: Mrs. Hedwig Sorli, Coordinator

Date: July 28, 1969

Subject: CAP-HS Form 48

Copies of the Medical Consultant's Evaluation Form are being distributed to you for completion after the final consultation visit to your local Summer Head Start Program.

We hope that this year we can better, or at least proximate, the 94% score of returns of last summer.

We appreciate your sustained support in efforts to evaluate our mutual undertaking.

HMS/ab
Enc.

DEPARTMENT OF PUBLIC HEALTH
DIV. MATERNAL AND CHILD HEALTH
25 BROAD STREET
BOSTON, MASS., 02110

Appendix H

MEMORANDUM

To: Public Health Consultants, for Head Start

From: Mrs. Hedy Sorli

Date: February 24, 1970

Subject: Head Start News (and enclosures)

CAP-HS Form 48

The information which was provided on CAP-HS Form 48 by both pediatricians and public health consultants (for summer 1969 Head Start Programs) is being processed statistically. Twenty-two pediatric consultants provided returns.

If your assigned pediatrician sent one to our office, we have attached a copy for you to retain, along with a copy of your own CAP-HS Form 48.

Mass. Cooperative Extension Program

The Mass. Extension Service is presently expanding the program of hiring and training Program Assistants drawn from low-income communities of the state to work with individual families in the area of food and nutrition. These Program Assistants are working in every county but Dukes. In one community instruction about the use of commodity foods is planned for Head Start Parents. More such teaching and demonstration could be planned if there is interest. Requests for information or assistance should be directed to your county extension agent in home economics, listed on the enclosed sheet. They can also provide you with more information about the on-going programs at the local level.

Accident Prevention

National Poison Prevention Week in March will again be highlighted with attendant publicity. If your local Head Start Director would like a supply of the enclosed Accident Handbook, we can make these available in quantity. Direct requests to this office.

Resolutions from National Head Start Conference included with January, 1970 Mailing of the American Academy of Pediatrics

Several of you have inquired about the source of this material. It was written by parents and transmitted to the Office of Child Devel pment for implementation. To date we have no information about subsequent developments.

HMS/ab
Encs.

Appendix I

MEMORANDUM

Subject: Recent Materials Related to Head Start Programs

To: Head Start Public Health Consultants

From: Hedy Sorli

Date: October 28, 1969

From time to time significant materials are received in central office. Some of these might serve to strengthen or expand or elaborate on various facets of Head Start Programs. We have been requested to try to share this information with you. If similar materials come to your attention, we will be glad to circularize these, too.

DENVER DEVELOPMENTAL SCREENING TEST

"The Denver Developmental Screening Test (DDST) was devised to provide a simple method of screening for evidences of slow development in infants and preschool children. The test covers four functions: gross motor, language, fine motor-adaptive, and personal-social. It has been standardized on 1,036 presumably normal children (two weeks to six years of age) whose families reflect the occupational and ethnic characteristics of the population of Denver."

In following through on an inquiry regarding this Test, it was possible for us to obtain a sample Test Kit for each Regional Office. (Please check yours if you are interested.)

The local Mead-Johnson sales representative assured us of cooperation in professional distribution of these items, on request. The reprint from the Journal of Pediatrics contained in the kit is a valuable review of the methods used to arrive at Test standardization. At the present time we have no further information about corroborative studies to ascertain its validity and reliability in universal screening.

BOOKLET Head Start on Health by Nancy Thomson, Information Specialist - Educational Resources Information Center, National Laboratory on Early Childhood Education, 805 W. Pennsylvania Ave., Urbana, Illinois 61801 - 1969 (Distribution -- one copy per Regional Office)

This booklet was prepared for the "less experienced preschool teacher." Mrs. Frances Olsen, Assistant Regional Training Officer in the Headstart Regional Training Office, reviewed this material for possibility of distribution and usefulness. She thought it was of limited value for "wholesale" distribution because, "It is simply a booklet of specific suggestions for fostering the development of health attitudes and habits in children. There is very little explanation of reasons behind the suggestions."

She further indicated that "I do think, however, that using a particular section as a springboard for discussion with a group of beginning teachers or teacher aides where one went into some of the "why" for the specific suggestions could be valuable.

"Most of the hints and suggestions are sound basically. At the end of the booklet there are lists of books, audio-visual aids and other sources of health information which could be very useful.

"In conclusion, I would recommend it be considered as one resource for the health director and the educational director of a Head Start to use in planning for better integration of health education into the preschool curriculum."

BOOK *On to the Classroom* - *Edited by Robert E. Clasen, Dembar Educational Research Services, Inc. Box 1148, Madison, Wisconsin 53701 (Cost - $7.25)*

Although this book is designed to be a guide for preschool teachers in Head Start-type Programs of compensatory education, its readable style and sound suggestions for meeting the needs of disadvantaged pre-school children ought to insure a wider audience. It will be of interest to public health workers because of its emphasis on programming based on the sound principles of child growth and development. The role of parents and programming for them is the subject of one chapter.

The chapter entitled "The Teacher, the Child and Head Start," particularly appealed to me because as the editor says of the author, Dr. Helen C. Dawe, "Teachers who are exposed to classes and readings on child development and the role of the teacher in facilitating that development sometimes come away from these experiences inspired but unable to transform what they have heard and read into action patterns in the classroom. Professor Dawe's knowledge, coupled with her experiences and her research orientation, enables her to offer the Head Start teacher some very specific guidelines about teaching the disadvantaged child."

Besides excellent bibliographies the book contains many succinct quotables, such as, "The teacher should know the nature of the child. She should know the nature of content and its related materials. She should know the nature of the learning process. She should also know herself -- her abilities, capabilities, and weaknesses. When she knows all these and puts them together to interact in a rich learning climate, she shouldn't expect learning miracles -- but she shouldn't be surprised if they happen."

Appendix J

MEMORANDUM

To: Dr. Sachs
Attn: Mrs. Ruth G. Murphy
To: Dr. Dunham
Attn: Mr. Merrill Plunkett
To: Mr. Joly
Attn: Mrs Agnes Keleher
To: Dr. Peterson
Attn: Mrs. Anna Leaheu
From: Hedy Sorli

Date: February 4, 1970

Subject: **Attached Report on Attendance at Head Start and Child Development Conference in Washington, D.C. and A REMINDER**

As you all know, the Head Start Program is now an operating unit of the Office of Child Development which at the national level is in the Office of the Secretary of the Department of Health, Education and Welfare.

The concomitant reorganisation of administrative structure is still on-going and there are still many guidelines to be developed. It became very apparent to those attending the Conference that tremendous importance is being placed on the necessity for involving parent groups in all aspects of program planning and development, both now and in the future.

We hope that as you continue to work with your local Head Start Program you might consider appropriate avenues for parent participation. You might even want to learn from the local Head Start Director the name of the local parent representatives who attended the Washington Conference so that they might participate in the implementation of effective health services programs for their own local Head Start Program.

A copy of my Report is attached for circulation to Regional Public Health Staff who might be interested in some personal impressions.

****

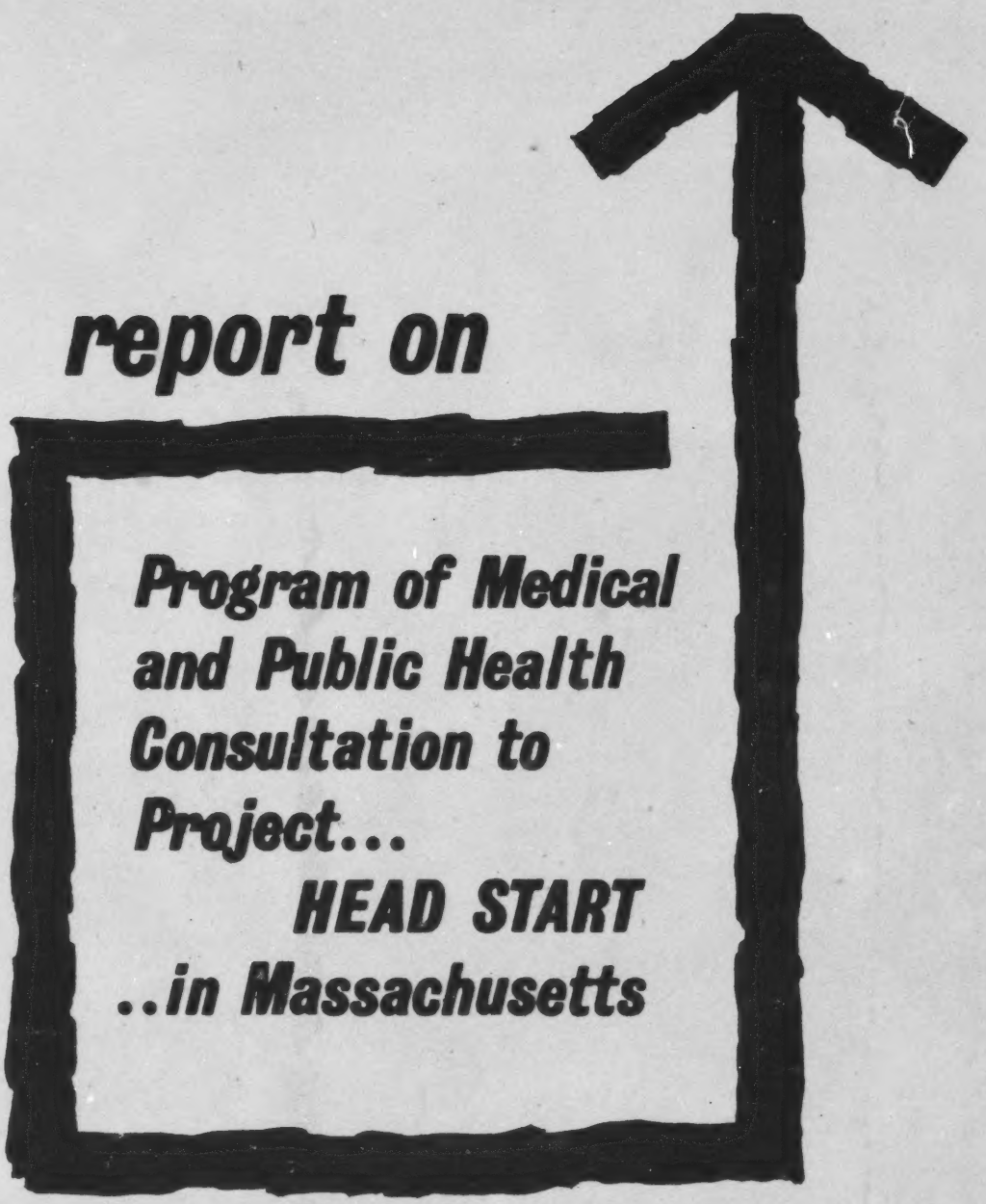
A REMINDER - URGENT

At the monthly meeting of the Day Care Services Staff, it was pointed out that some Head Start Directors do not understand the requirements for Day Care Licensing. Appropriate interpretation and understanding of the need for maintaining desirable standards is a continuing responsibility.

Is the Head Start Program to which you provide consultation licensed?

Please circulate to:

SE-Miss Ruth Irwin, Miss Jane Gallahue, Mr. Howard Wemley, Miss L. McManus Mr. Tony Caramello, and Mrs. Bernadine Tassanari
SE-Miss Bernice Jegal, Miss Dorothy Harrington, and Mrs. M. Walkling
Central-Mrs. L. Patterson, Mrs. M. Coppage, Mrs. M. Brown & Miss M.C. Donahue
Western-Miss M. Clowson, Mrs. D. Lisman, Miss I. Burns, & Mrs. C. Downing



report on

Program of Medical and Public Health Consultation to Project... HEAD START ..in Massachusetts

Massachusetts Department of Public Health
February, 1969

Report

PROGRAM OF MEDICAL AND PUBLIC HEALTH CONSULTATION

TO

PROJECT HEAD START IN MASSACHUSETTS

Project Director: M. Grace Hussey, M.D., M.P.H.
Project Coordinator: Hedwig M. Sorli, Ed.M., M.P.H.
Division of Maternal and Child Health Services
Massachusetts Department of Public Health

In fulfillment of requirements
Under Contract #B89-4450 with Office of Economic Opportunity
Procurement Division
May 1, 1968 - February 28, 1969

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V. APPENDIX

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For Pediatricians

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I. INTRODUCTION

Head Start Programs incorporating a health services component have been functioning in Massachusetts since the summer of 1965. Standards for health services are explicitly set forth in the Office of Economic Opportunity guidelines for project directors and health personnel. Translating goals and requirements into quality local programs involves the complex of variables existing in any given community setting. The size and resources of the community, the availability of competent staff, and the extent of community involvement are all factors influencing the development of local programs. Each program must be planned and developed on an uniquely individual basis, for no two are exactly alike in the inter-relationships of community variables.

In 1967 an experimental plan for providing medical and health consultation to local programs was implemented on a state-wide basis under contracts between the Massachusetts Department of Public Health and the Office of Economic Opportunity.

A demonstration program under the direction of the Division of Local Health Services of the Massachusetts Department of Public Health provided health team consultants for assistance to fifty local Head Start Programs during the rather limited period of Summer, 1967. The consultant contributions were acclaimed as successful with the recommendation that they be extended to include full year as well as summer programs. In evaluating their experiences, pediatricians and public health staff who had been participants indicated program modifications which would result in earlier involvement in the program and more comprehensive planning.

As a result, the Department of Public Health assigned responsibility for coordinating a continuing program to the Division of Maternal and Child Health Services and submitted a new proposal to the Office of Economic Opportunity in November, 1967 incorporating these changes. The new proposal envisaged continuity of the demonstration to insure some stability in the relationships between consultants and consultees, better interpretation of the health services objectives, and the stimulation of more effective community participation for program improvements.

On December 29, 1967 official Community Action Program Memorandum #78 on the subject of "Medical Consultation for Head Start Programs" was distributed to all program directors in the United States by the Office of Economic Opportunity.

The memorandum indicated that the Massachusetts Department of Public Health would be responsible for the management of the program in its own state. It further indicated that consultant responsibility would be a continuing one and "The same consultant will be available over a period of several years and will offer consultation for summer Head Start, full-year Head Start."

Preparatory to the inauguration of the proposed continuative consultant program, an Inter-departmental Committee was set up to serve as liaison in planning and developing orientation sessions for all consultants at three area Conferences held in January, 1968. (Members of this Inter-departmental Committee included representatives of the Departments of Public Welfare, of Mental Health, the Commonwealth Service Corps, and the Department of Public Health.)

Participants at these Conferences included those who had served as consultants (medical and public health) to Summer, 1967 programs and those who would staff teams for the 1968-69 year-round and summer programs.

The Conference purpose was two-fold and the program was so designed. The first aspect had to do with evaluation and a review of the Summer, 1967 experiences. The second part was given to orientation of new consultants. Three position papers were prepared and distributed to all conferees in advance of the meetings. They related to: (1) Final Report on the Medical and Health Consultation Program of Summer, 1967, (2) "The Public Welfare Study," and (3) Some considerations posed by the Head Start Coordinator of the State Technical Assistance Office. Thus in January, 1968, participating staff had been primed for action. All materials for distribution in Kit form had been prepared and assembled, and team assignments had been blueprinted. Unfortunately, our Contract was not validated until late in May. As soon as approval was received, we activated teams to serve year-round programs. We realized that contacts would be made, in many instances, just as programs were preparing to close. However, since we envisaged continuity on future programs, we urged staff to set up conferences and visits wherever possible.

The second phase involved the activation of teams to serve summer programs. Again we felt that due to these circumstances beyond our control, we entered this program too late. The majority of consultants felt the need for being involved when the program was being planned before the proposal was written.

Despite these drawbacks, the staff responded promptly and indicated great commitment to their consultant responsibilities. Out of a total of sixty-eight responses to the evaluation question of whether or not the program was worthwhile and should be continued, only three did not want the program continued.

The Report which follows is based on the material provided by knowledgeable consultants who did the work for our twenty-three year-round and forty-one summer Head Start Programs. Individually and collectively they tried to coordinate, integrate, and communicate at all levels to insure comprehensive planning, community involvement, and competent staff to deliver quality health services to children enrolled in Head Start.

II. PROGRAM PURPOSE AND SCOPE

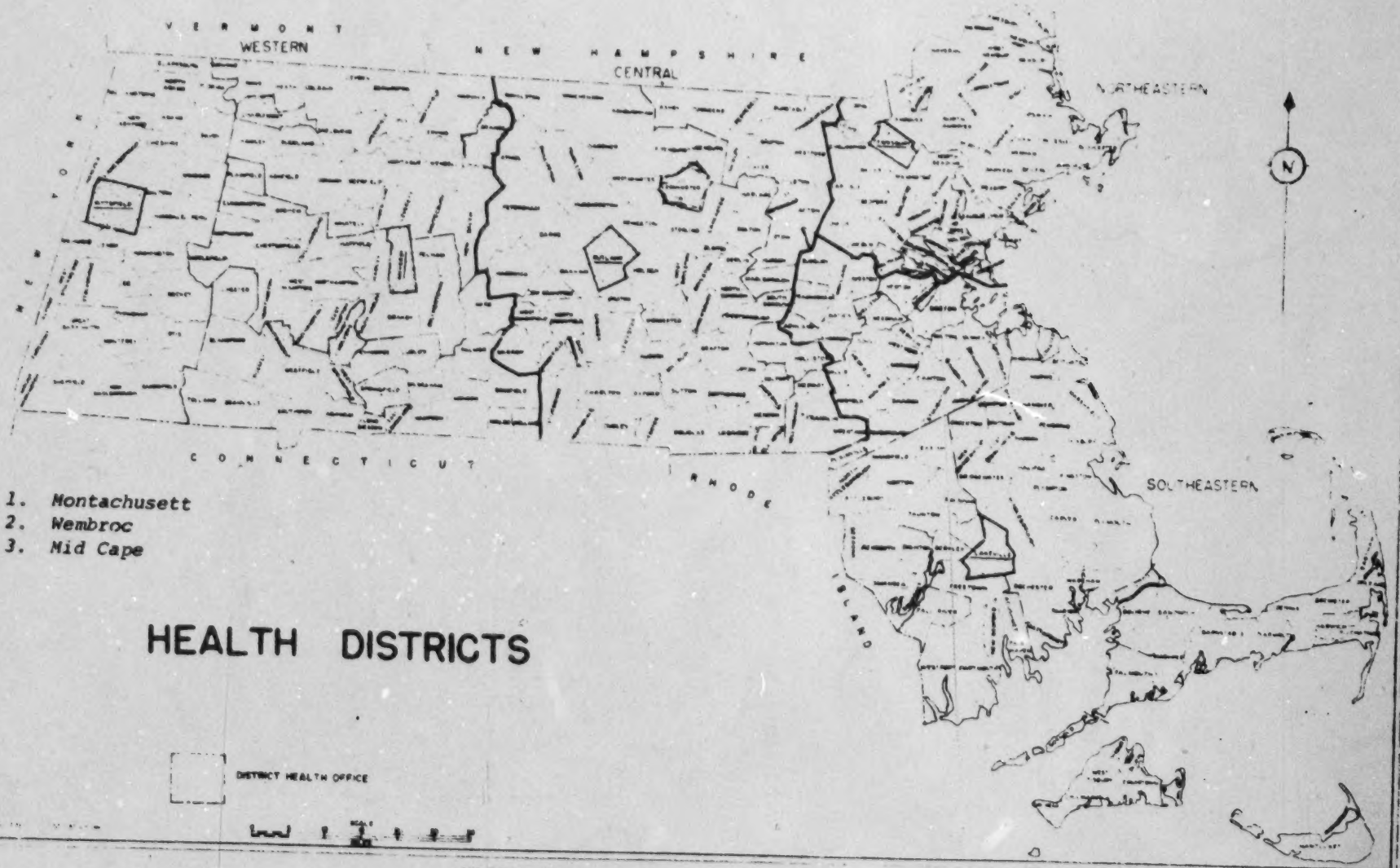
The Massachusetts Department of Public Health, under contract with the Office of Economic Opportunity, has provided medical and public health consultation teams to help develop Head Start Health Programs of high quality in the Commonwealth. The contract awarded was dated May 1, 1968 for a ten-month interval to terminate on February 28, 1969. This report reflects activities undertaken during this time sequence, as well as program planning and other developments immediately preceding it.

As mentioned earlier, a somewhat similar program had been funded for consultation to Summer, 1967 Head Start Programs. The protocol for consultation in 1968-69 attempted to follow the recommendations for program modification which resulted from evaluation of this first Departmental experience in 1967. The 1968-69 Project retained the "team" organizational pattern for consultation to 23 year-round as well as 41 summer programs. These local programs are indicated on the accompanying maps (pages 4 and 6), and are listed alphabetically on pages 5 and 7.

The Project was undertaken with the cooperation of the Massachusetts Chapter of the American Academy of Pediatrics, the Commonwealth Service Corps (which later became absorbed by the newly created Massachusetts Department of Community Services), and the Massachusetts Departments of Public Welfare and Mental Health. (During 1967 there was need felt for a mental health consultant team member. The Commissioner of Mental Health was approached before the 1968 contract proposal was drafted in order to solicit his cooperation. This enabled the addition of a mental health professional to the original team of three.) In addition, a Public Health Advisory Committee was set up to develop guidelines for program development, orientation of staff, and advice on the preparation of kits and other necessary written materials for the guidance of staff.

The organizational chart on page 8 is an attempt to schematically present the inter-relationships between agencies and personnel involved in the consultation program.

Forty-eight multi-disciplinary consultant teams were organized to involve four expert members representing (1) public health, (2) public welfare, (3) mental health, and (4) pediatric practitioners. Each team worked with the local Community Action Agency, the Head Start director, and his health staff to review the health and medical aspects of the community's Head Start project proposal to provide adequate planning for medical and health care of every child enrolled. In addition, sustained consultation was maintained to insure community understanding and full utilization of community and health referral resources. When necessary, the team assisted in the development of innovative approaches for provision of needed but missing services. In addition to medical examinations and follow-up of children with defects, the local goal was to involve parents in planning and to motivate them to understand and seek future and continuing medical care for their children and other family members.



MASSACHUSETTS HEAD START PROGRAMS
Year Round, 1967-68
23 Teams

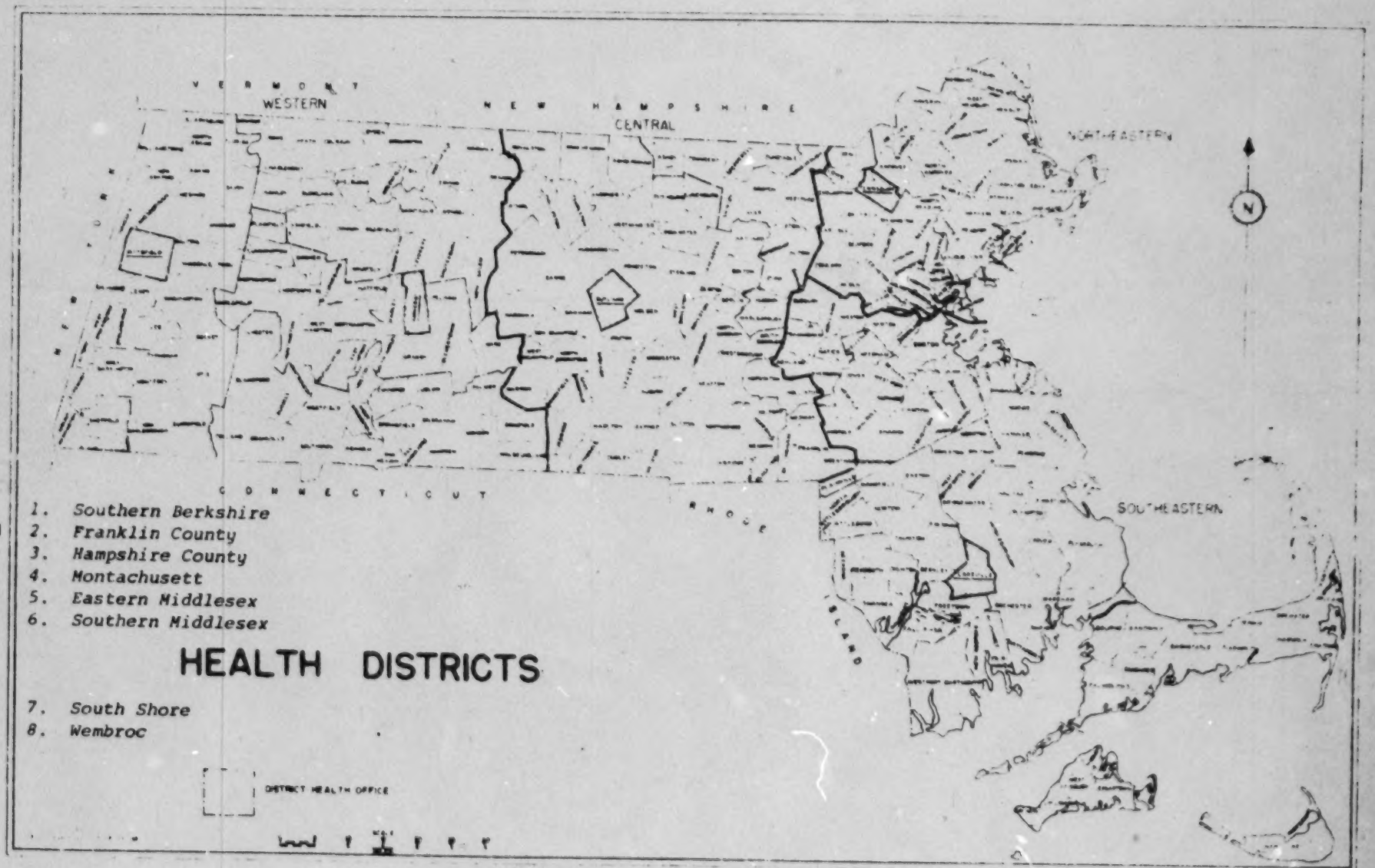
MASSACHUSETTS HEAD START PROGRAMS

Year Round, 1967-68

23 Teams

Alphabetical Listing

Barnstable
Boston
Bourne
Brockton
Cambridge
Fall River
Falmouth
Franklin County -- Charlemont
Franklin County -- Orange
Gloucester
Holyoke
Lawrence
Lowell
Lynn
Mid-Cape
Montachusett
New Bedford
Pittsfield
Southern Middlesex
Springfield
Taunton
Wembroc
Worcester



MASSACHUSETTS HEAD START PROGRAMS
Summer, 1968
41 Centers

MASSACHUSETTS HEAD START PROGRAMS

Summer, 1968

41 Centers

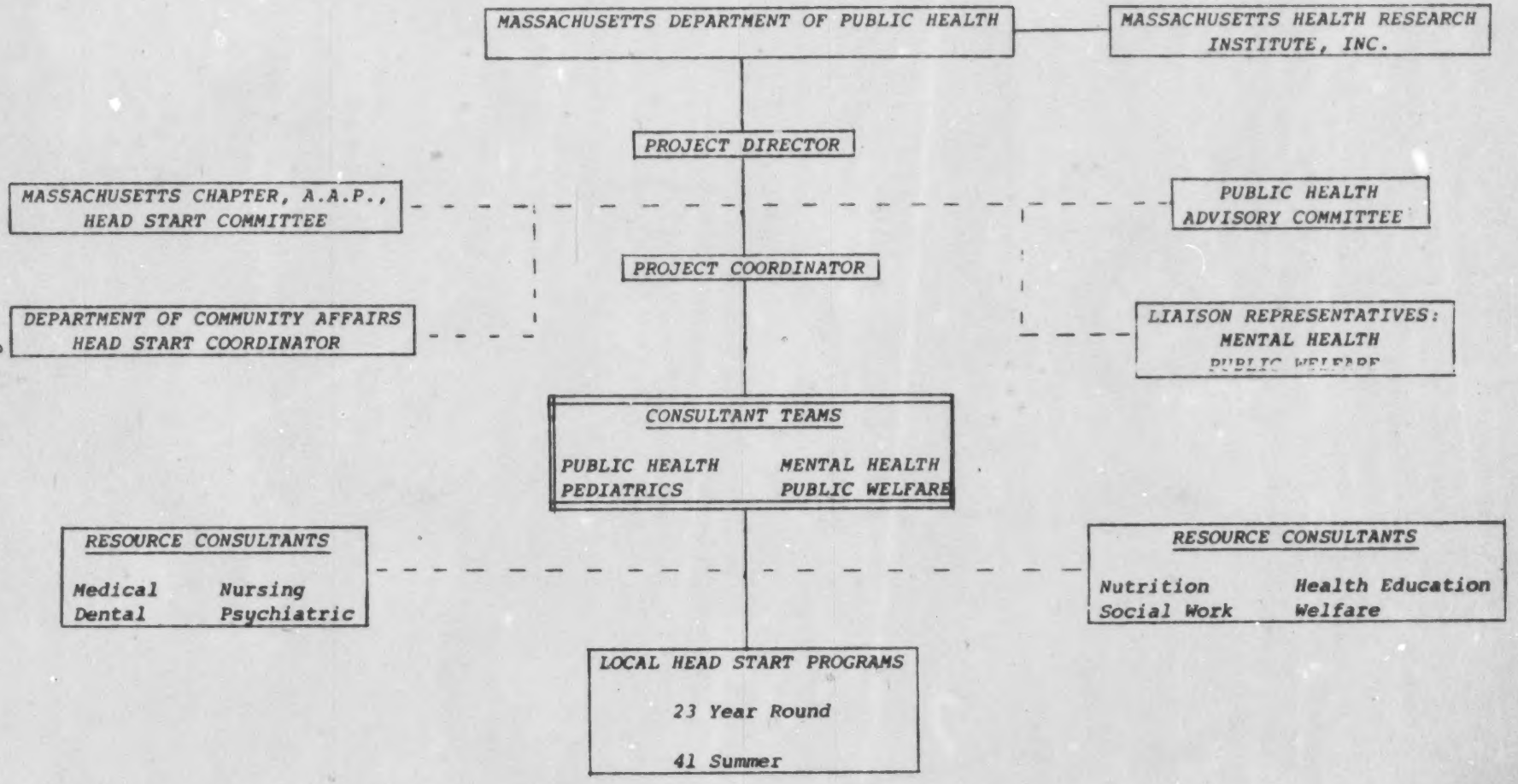
Alphabetical Listing

Barnstable
Boston
Bourne
Cambridge
Chelsea-Revere
Chicopee
Eastern Middlesex
Fairhaven
Fall River
Falmouth
Franklin County
Gloucester
Hampshire County -- Ashfield
Hampshire County -- Northampton
Haverhill
Lawrence
Lowell
Martha's Vineyard
Mashpee
Montachusett
- *Ashburnham*
- *Athol*
- *Fitchburg-Leominster*
- *Gardner*
- *Lunenburg*
- *School Union 1*
- *Townsend*
- *Winchendon*

New Bedford
Norton
Plainville
Quincy
Salem
South Shore -- Marshfield
South Shore -- Plymouth
Southbridge
Southern Berkshire
Southern Middlesex
Wembroc
Westfield
Wilmington
Worcester

PROJECT HEAD START IN MASSACHUSETTS

MEDICAL AND PUBLIC HEALTH CONSULTATION



The two consultants from the health field helped in planning for and achieving the medical and health goals of Head Start, as set forth in the guide developed by the Office of Economic Opportunity. The public welfare representative interpreted the State Medical Assistance Program (Medicaid) and suggested methods for its full utilization. The mental health representative advised in related program areas and the utilization of referral resources for emotional and psychological problems.

The total enrollment of children in summer programs was approximately 5,286. The largest program was in Boston with 1,012 children and 56 classes; the smallest was in Ashburnham with 20 enrollees and one class. On a county basis, the following were the enrollment figures provided to us by the Office of Economic Opportunity:

COUNTY	ENROLLMENT
Barnstable	272
Berkshire	90
Bristol	463
Essex	678
Franklin	60
Hampden	170
Hampshire	150
Middlesex	1,027
Norfolk	136
Plymouth	228
Suffolk	1,250
Worcester	762

At this writing accurate figures are not yet available for year-round enrollments.

CONSULTANT ASSIGNMENTS

Pediatricians

Dr. Allan Stimson, Chairman of the Head Start Committee of the Massachusetts Chapter of the American Academy of Pediatrics, was responsible for recruiting pediatrician consultants.

He addressed an "inquiry of interest" questionnaire to the members of the Massachusetts Chapter, American Academy of Pediatrics. The response to the request for consultants was enthusiastic. In commenting on these responses, he reported to his colleagues as follows:

> "One week after mailing the Head Start Consultant Questionnaire, replies have been received from 62 physicians who are "very interested" in serving as consultants in the full-year Head Start Programs. Inasmuch as there are only 23 full-year programs, it is not possible to use all those who are interested. For the present it is planned to use those physicians who have served in the past and to hold the names of others for consideration in future programs."[1]

1. NEWSLETTER, Mass. Chapter, American Academy of Pediatrics, Jan. 1968, page 3

The President of the Chapter, Dr. Sprague Hazard, in commenting on these results, informed his colleagues as follows:

> *"From this reservoir of physicians (noted above) who cannot immediately be used as consultants, as well as an additional fourteen others who indicated "moderately interested", there is a valuable group of eager and willing pediatricians who could provide enormous contributions as medical directors or advisors to Head Start Programs in their own communities."*[2]

Assignments were made from this list of "self-elected" pediatricians with the approval of Dr. Stimson's Head Start Committee. It was agreed that physicians from the list who served on the 1967 program would continue to provide consultation to the same community wherever possible. Any administrative problems were to be resolved by decision of the Massachusetts Chapter, Head Start Committee.

Forty-one individual pediatricians received community team assignments. Of this number, thirty-one served one community; nine served two communities; and one served four communities.

In those communities where there was both a year-round and a summer program, the same pediatrician served both programs with only one exception. In this one instance, the assigned pediatrician was not available during the summer. A replacement was made for summer-only consultation. One pediatrician found it necessary to withdraw the day before his scheduled summer visits to two communities, and it was impossible on such short notice to find a replacement.

Public Health Generalists

Due to public health staff turnover and other problems, not all State Health Department staff who served during Summer, 1967 were able to continue in 1968-69. Regional Health Officers were given the lists of Head Start Programs within their health jurisdictions and asked to make assignments. Members of the central office staff of the Division of Maternal and Child Health Services were assigned to those communities lying east of the boundary presented by State Highway Route #128. Local health departments with full-time medical health officers had provided consultation teams in 1967. With the exception of the City of Boston, they agreed to continue this arrangement. (Because Boston lies within the #128 boundary, a staff member from central office undertook this assignment.)

Thirty individuals with public health orientation but representing a variety of different professional disciplines agreed to accept team assignments. Of this number, twenty-five were from the Massachusetts Department of Public Health; four were from local health departments; and one was from an island community Visiting Nurse Association. The chart which follows indicates the range of professions represented among the public health generalists.

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2. Ibid, page 3.

Professions Represented by Public Health Generalists

Generalists on Summer Programs	*Number of Participants*
Public Health Nurses	*23*
Public Health Social Workers	*6*
Public Health Educators	*3*
Public Health Dental Hygienists	*3*
Public Health Physicians	*2*
Public Health Nutritionists	*2*
Public Health Physical Therapists	*2*
Total	*41*

Generalists on Year-Round Programs	*Number of Participants*
Public Health Nurses	*17*
Public Health Social Workers	*3*
Public Health Educators	*2*
Public Health Physician	*1*
Total	*23*

Twenty-nine individuals were assigned to assist the forty-one summer Head Start Programs, while eighteen were assigned to the twenty-three year-round programs. Usually, if a community sponsored both a summer and a year-round program, the same public health generalist served both.

Probably a more descriptive term for the role of the so-called "public health generalist" would be "regional public health consultant." Implicit in the assignment of the "generalist" was the fact that through this individual, other public health specialist consultants could be made available to a local Head Start Program if and when needed.

The public health generalist functioned as the leader and initiator of the team consultation visits and had the responsibility for continuity of this service. In addition, the generalist served as interpreter of the goals of the consultation process. Sometimes the generalist was liaison person with other community resource agencies, as well as coordinator and innovator in developing new potentials for service.

It was the public health generalist who provided this Project with a "process record" of what actually occurred in the myriad of contacts with local programs. These records indicate the nature of contacts such as telephone calls, personal and group conferences, a description of problems encountered, of major recommendations, and of accomplishments. This record keeping was undertaken to assess the amount of time expended by public health staff, the nature of the participants' public health

contributions to local programs and to attempt to delineate major problems. These are reported on in the section on Evaluation.

Public Welfare Consultants

The Massachusetts Department of Public Welfare liaison representative to the Inter-departmental Committee provided the list of community consultants who were drawn from the staff of either the central office, a regional office, or a local office. The total number of individuals involved was twelve.

Mental Health Consultants

During the interval when the project consultation became operative, the Massachusetts Department of Mental Health was reorganizing and implementing a master plan for the establishment of regional area subdivisions. Staffing and recruitment were major problems, yet despite these drawbacks the Massachusetts Department of Mental Health liaison representative was able to provide the Project with a listing of mental health professionals through whom representation was to be sought for service on the consultation team. The total number of such persons was twenty.

COMMUNICATION SYSTEMS

Orientation of Consultant Team Members

Early in 1968 representatives from the Massachusetts Departments of Mental Health and Public Welfare met with public health generalists and team pediatricians at half-day regional conferences to discuss the Head Start Consultation Program.

Each cooperating group assumed the responsibility thereafter for orientation of its own representatives assigned to the program. In staff conferences, by written materials, and in other ways, the Departments of Mental Health and Public Welfare reached their own staff. One individual from each Department was assigned as liaison to our Project. Mr. Aaron Coville from the Department of Public Welfare and Dr. Herbert Siegert from the Department of Mental Health ably carried out their communication roles.

The Head Start Committee of the Massachusetts Chapter of the American Academy of Pediatrics cooperated to the fullest extent in interpreting to their entire state chapter membership the procedures and activities of the Project and the contributions of their involved colleagues. All decisions relating to participating pediatricians were jointly arrived at by Project staff and the Head Start Committee. For example, it was agreed that the fee schedule established for pediatric consultation would be similar to that determined by the Office of Economic Opportunity contract with the American Academy of Pediatrics. Problems relating to a specific situation were referred to the Chairman of the Head Start Committee.

Dr. Allan Stimson of New Bedford served as Chairman during the initiation of the program and later turned this responsibility over to Dr. Benjamin Sachs. The Chapter Chairman, Dr. Sprague Hazard, was also available at all times to provide assistance, support, and guidance.

Three meetings with representatives of the Massachusetts Chapter and Project staff were held to discuss problem areas, report on program developments, and evaluate mutual experiences in terms of modifications of procedures to achieve Project objectives.

Public health staff members, both state and local, who became involved as generalists in the Massachusetts Project are highly competent professionals familiar with both the consultation process and the inter-disciplinary team approach to problem solving. They are knowledgeable about community health resources since the majority of them work at the community level and many of their activities relate to responsibilities in other areas of child health services such as day care licensing, school health programs, and family-centered public health nursing. Therefore, emphasis of their orientation was to the Head Start Health Program and the goals and procedures of the Massachusetts Project. These were defined in written materials assembled and distributed in kit form. (See Appendix.) The kits also included "Profiles" of the local Head Start Health Programs which were made available by the Technical Assistance Office of the Commonwealth Service Corps.

The Generalists of each Regional Health Office were visited by the Project Coordinator to discuss these materials, answer questions, and share relevant experiences.

Reports

An extensive reference file of community reports on Head Start has been accumulated by the Project office during the reported ten-month interval. Pediatricians were required to complete a report on each site visit. (See Appendix for form.) Generalists were expected to complete reports on every activity in behalf of a local program. (See Appendix.) These included telephone calls, letters, conferences, site visits, etc. and included a statement on the amount of time spent. As a result some excellent "process records" are now available, which document the methodology and comprehensive planning entailed in involving community participation in providing Head Start Health Services. (We hope at a future time to be able to more fully analyze and report on this information.)

The system of reporting to Office of Economic Opportunity Regional and Washington Offices was defined in our Contract as a monthly activity. In addition to these written records, we had no inhibitions about telephoning to relay questions or pertinent information. Copies of reports provided by pediatricians were sent regularly to both the New York and the Washington Regional Offices. They were also shared with the generalists and the Head Start Director. Regular feed-back was thus attempted. Reports were written on all meetings and conferences attended by the Project Coordinator. These were circulated to generalists and/or pediatricians.

We attempted to provide a telephone information and referral system from central office, and kept a log of telephone calls received. Most calls related to specific questions about program content or a problem area. However, in quite a few instances the telephone was used for "ventilation of feelings," such as frustrations about late involvement, etc. Hopefully central office staff provided a supportive function. Another situation evident from a review of the "telephone log" is the need on a new program for constant repetition and interpretation of basic information. A great many calls were received from both pediatricians and generalists which asked about program elements reviewed in conferences and defined in writing. There was the need at first to have somebody in authority always available to restate, reiterate and repeat program goals and procedures.

Commentary

One additional role of the Project Director in any new program is to be a communicator or to facilitate communication by every available means. Even though it was possible to hold periodic regional meetings, area staff meetings, personal conferences and to disseminate much written material related to Head Start Health Services, there is further need for even better and more extensive communication. The field representatives in the Office of Economic Opportunity Regional Offices should get to know and relate more effectively with our Consultant Teams. At the local level, dental and medical societies need to be better informed about Head Start and its medical component. We would also like to see a Newsletter or some such device prepared and distributed on a regular basis. This will require additional manpower either at the federal level or the state level.

We have been extremely fortunate in the cooperation provided by all participating agencies. The Technical Assistance Head Start Coordinator, however, deserves special mention because in every aspect of communication requiring joint participation she was active. If information was received in the Office of Technical Assistance relevant to the Massachusetts Project, it was always relayed. All census data, community action information and anything else that could help us to develop a better program was jointly shared.

Recently, the Massachusetts Department of Public Health recruited staff to serve as Coordinators of Day Care Programs in Regional Health Offices. Since Head Start is a form of Day Care Service, these individuals are serving as liaison to other public health generalists based in the Regional Health Office areas. The Day Care Coordinators hold monthly staff conferences to share information on Head Start developments which they in turn relay to other generalists when they return to their Regional Health Offices.

III. EVALUATION

PROCEDURAL ASPECTS

In the original project proposal submitted to the Office of Economic Opportunity, a budgetary item to insure program evaluation assistance was included. Unfortunately this item was deleted from the funded proposal, with the understanding that a standardized evaluation instrument would be developed for national use by the Office of Economic Opportunity Washington Office. Our evaluation data therefore was to be, in part, derived from this evaluation form and would be tabulated for us.

This did not prove to be the case. Instead, although the forms, "Medical Consultant's Evaluation of Head Start Health Services," CAP-HS Form 48 (Rev. Jun 68) were sent to us to be completed, we are indebted to Bio-dynamics, Inc. of Cambridge for processing of the completed forms for Summer, 1968 programs in Massachusetts at no cost to us. Bio-dynamics, Inc. tabulated data for all other programs in the country on a standardized basis, thereby providing us with the means to compare our figures with other states.

Even cursory review indicates that our pediatricians did an outstanding job of cooperation in completing and returning CAP-HS Form 48. Ninety-two per cent completed copies for programs which represented 94% of the children enrolled (4,983 children). No other state in the union with a similarly large number of consultant assignments achieved such a high level of cooperation!

Since our Project does not have access to a computer or data processing equipment, we utilized the data provided us by Bio-dynamics, Inc. as the basis for analysis, together with our own compilation of data. We had asked both our pediatric consultants and our public health generalists to complete CAP-HS Form 48. The interpretation and tables which follow are based on the juxtaposition of figures available from these two sets of respondents, identified as pediatricians and/or generalists.

Although as mentioned earlier we served 41 summer programs, we accepted the Bio-dynamics, Inc. guidelines "established to provide a standard basis for determining the number of consultant assignments made and the number of reports received." The application of such standards credited us with 36 programs and 33 completed CAP-HS Form 48's even though we had sent them 38 completed forms.

Their determination of this basic standard they describe as follows:

> "The basic assignment unit was the grantee agency. If one consultant was assigned to one grantee agency, this was counted as one assignment, and only one report was expected, regardless of the number of component/delegate agencies within that grantee agency. If more than one report was submitted for a grantee

agency, all reports for component/delegate agencies within that grantee were combined (by averaging the answers to each question) into a single report. Such combining of reports was necessary for 33 grantee agencies.

"If one grantee agency was divided between two (or more) consultants, it was counted as two (or more) assignments and each consultant was expected to submit one report on his portion(s) of the grantee agency.

"If one consultant was assigned to all or some part(s) of each of two (or more) grantee agencies, then it was counted as two (or more) assignments, and the consultant was expected to submit one report for each grantee agency with which he worked, whether he worked with all or only some portion(s) of that agency."[3]

The following explanatory note is also necessary:

"Massachusetts -- the medical consultation program in the state utilized a team approach. The team was composed of a pediatrician and a public health generalist. When reports of a pediatrician and public health generalist were both available, for a given program, the pediatrician's report was used. When the public health generalist's report was the only one available, it was used. Of the 33 reports tabulated here, 28 were completed by pediatricians and five were completed by public health generalists. Of the five public health generalists who completed reports, two were physicians."[4]

The total of sixty-eight reports tallied include thirty-three from pediatricians and thirty-five from public health generalists.

Bio-dynamics, Inc. due to cost involved was unable to tabulate or classify the responses to the open-ended questions #16 and #17 on "The Consultation Process" on page 4 of the form. We consider this information of particular value for future program modifications. We also feel that it gives some insight into the differences of approach between the clinician and the public health professional. Even further we have a strong conviction that both types of specialists are needed if the highest quality of comprehensive health programming is to be achieved.

For these reasons we have not only summarized and categorized the responses to questions #16 and #17 but have even documented responses verbatim for those local programs for which two CAP-HS Form 48's were received, one from the pediatric consultant and one from the public health generalist.

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3. "Statistics from Medical Consultant's Evaluation of Head Start Health Services for the 1968 Summer Head Start Programs." Published by Bio-dynamics, Inc., 33 Cambridge Parkway, Cambridge, Mass. 02142. 27 December 1968. Pages VI, VII.
4. Ibid, page VII.

A copy of CAP-HS Form 48 is inserted following this page.

CONSULTANTS' EVALUATION OF HEAD START HEALTH PROGRAM

(EXPLANATORY NOTE: In the commentary which follows, dual percentage figures are taken from the tables indicated. They are the percentage response of the pediatricians and the percentage response of the generalists respectively.

In addition, we have elected to add information derived from narrative reporting which seems relevant for further amplification of the statistical data provided.

Material is arranged in the same order as it appears in CAP-HS Form 48.)

Planning

As indicated in Table 1. consultants reported the involvement of many community agencies in the planning phases of local programs. A particular target for involvement this year was the school program. With reports of 64%-69% of these involved, it would appear that there was a reasonable degree of success in achieving this goal. Only the extent of the involvement of welfare departments (as reported 67%-77%) exceeded these percentages. The welfare departments' role was built into the program by consultation team assignment.

As in the past, data indicate the need for greater effort to involve the membership of both the medical and dental societies. Only a small number were involved. This is further substantiated in many of the comments made in consultants' reports on program inadequacies.

The responses to the second question of how meaningful was the participation of important community health resources indicates a degree of relative success: "very successful" 33%-34% to which can be added "partially successful" 39%-40%. However, if these responses are compared with responses to the first question of "substantial involvement" it would appear that a contradiction of sorts exists, which is inherent in the question asked. For the response of "very successful" reported as 33%-34% to question two, is in contrast to responses to question one reporting "substantial involvement" by 58%-49% of health departments, by 67%-77% of welfare departments, and by 64%-69% of school departments.

Consultants rated the adequacy of the local plan to meet health goals as superior in 27%-23% of the instances and adequate in 48%-54% of instances. Only one plan was rated inadequate. In suggesting program modifications many consultants reported that while Program Directors had a much better understanding of health program goals this year, the planning started too late; or provisions were not made to obtain competent staff, or because no medical director had been appointed, coordination could not be effected.

MEDICAL CONSULTANT'S EVALUATION OF HEAD START HEALTH SERVICES

DATE OF EVALUATION

Form Approved
Budget Bureau No. 116-R0119

REPORTS CONTROL SYMBOL
OEO-CHE13

NAME, ADDRESS AND TELEPHONE OF GRANTEE

NAME AND ADDRESS OF CONSULTANT

NAME, ADDRESS AND TELEPHONE OF DELEGATE AGENCY *(if different than Grantee)*

INSTRUCTIONS

Each medical consultant should complete a copy of this form for each health program which he visits and evaluates. Usually, one for each grantee. When differing health programs serve different delegate agencies under the same grantee, the consultant may submit a separate report for each such health program.

The questions are subjective and evaluative because simple factual data can be gathered directly from the project without using the time and talent of consultants. The answers should be based on the consultant's total evaluation after talking with the many people concerned with the Head Start Health Program; teachers, physicians, the health director, the Head Start director, parents, and others. The consultants should attempt to obtain sufficient information to make a judgment about each of the questions asked. Whenever possible, he should examine individual health records and program records in order to obtain objective information on which to base his subjective opinion.

The consultant should feel free to discuss his evaluation with those responsible for the Health Program. He may wish to give a copy of this evaluation report directly to the health director or program director. Any findings or recommendations which he feels could not be productively utilized by the local program, but which are important to the Regional or National OEO Office, should be reported by letter.

I. PLANNING

1. Which of the following were substantially involved in PLANNING the Head Start Health Program? *(had a large enough role to feel some responsibility for results)*

- ☐ HEALTH DEPARTMENT
- ☐ WELFARE DEPARTMENT
- ☐ SCHOOL HEALTH PROGRAM
- ☐ MEDICAL SOCIETY
- ☐ PEDIATRIC ASSOCIATION
- ☐ DENTAL SOCIETY

2. How successful was the health program in obtaining meaningful participation of all important community health resources in planning the Head Start Health Program?

- ☐ VERY SUCCESSFUL *(most existing agencies and practitioners participated)*
- ☐ PARTIALLY SUCCESSFUL
- ☐ LITTLE SUCCESS *(program planned and executed by a single physician or agency or only a few)*

3. Did the PLAN for health services appear to be adequate to meet the health goals of Project Head Start? *(disregard difficulties in implementation not inherent in the plan itself)*

- ☐ SUPERIOR PLAN
- ☐ ADEQUATE PLAN
- ☐ PLAN WITH INADEQUACIES
- ☐ GENERALLY INADEQUATE PLAN

II. PROGRAM

4. Were participating physicians well informed about goals and guidelines of Head Start Health Programs and their precise roll in it?

- ☐ VERY WELL INFORMED
- ☐ ADEQUATELY INFORMED
- ☐ INADEQUATELY INFORMED

5. Was the medical program carried out in such a way as to be convenient, comfortable and dignified for the children and parents? Did the participating physicians appear to be concerned about the dignity and comfort of the Head Start children and parents?

- ☐ VERY MUCH SO *(private patient status or better)*
- ☐ TO A LARGE EXTENT
- ☐ TO ONLY A SMALL EXTENT *(hard benches, long waits, impersonal treatment, "mass production" exams)*

6. Were parents present at the time of the physician's health evaluation?

- ☐ ALMOST UNIVERSALLY SO (95%+)
- ☐ LESS OFTEN *(estimate percentage)* _____ %
- ☐ INFREQUENTLY *(less than 15%)*

II. PROGRAM *(Continued)*

7. Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components.

- ☐ WELL INTEGRATED AND COORDINATED
- ☐ PERIPHERAL TO REST OF PROGRAM BUT NOT DISRUPTIVE
- ☐ SCHEDULED SO AS TO DISRUPT OR INTERFERE WITH OTHER COMPONENTS OF PROGRAM

8. Was the health program planned and organized so that children could obtain continuing care *(during and after Head Start)* from the physician examining and treating him in Head Start?

- ☐ TO A GREAT EXTENT (80%+ *of children)*
- ☐ TO A MODERATE EXTENT
- ☐ TO LITTLE OR NO EXTENT *(25% or less)*

III. RECORDS

9. Were individual health records of sufficient detail and quality to serve as a basis for all future treatment and health supervision? *(so that you would require little further history if child came to your office for care)*

- ☐ VERY MUCH SO
- ☐ ADEQUATE
- ☐ INADEQUATE

10. Was there a checksheet, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?

☐ YES ☐ NO

Did it accomplish its purpose?

- ☐ ADEQUATELY
- ☐ INADEQUATELY

11. Were health program records, statistics and summaries adequate to serve as a basis for realistic planning and budgeting of FUTURE health programs?

- ☐ VERY MUCH SO *(clear record of activities, findings, treatment results and costs)*
- ☐ ADEQUATE *(some record of immunizations, findings on tests, exams, costs)*
- ☐ INADEQUATE

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IV. SUMMARY EVALUATION

12. How well did this program succeed in achieving each of the goals listed below?	HIGH SUCCESS	MODERATE SUCCESS	SLIGHT SUCCESS
a. Finding Health Defects through:			
TEACHER'S OBSERVATIONS			
SCREENING TESTS			
PHYSICIAN'S EXAMINATION			
PAST HEALTH RECORDS			
b. Treating Health Defects			
MEDICAL			
DENTAL			
PSYCHOLOGICAL			
c. Preventing Future Health Problems through:			
IMMUNIZATIONS			
FLOURIDE DENTAL TREATMENT			
HEALTH EDUCATION			
INTRODUCING CHILD TO PHYSICIAN AND DENTIST WHO CAN PROVIDE FUTURE CARE			
d. Improving Health of Family Members by:			
CALLING ATTENTION TO FAMILY HEALTH NEEDS			
INTRODUCING FAMILY TO SOURCES OF HEALTH CARE FUNDS AND SERVICES			
e. Improving the Health of the Community through:			
INCREASING AWARENESS OF HEALTH PROBLEMS OF POOR CHILDREN			
STIMULATING NEW RESOURCES TO PROVIDE AND PAY FOR CHILD HEALTH CARE			
MAKING EXISTING RESOURCES MORE RESPONSIVE TO THE SPECIAL NEEDS OF THE POOR			

V. IMPACT

13. To what extent did the Head Start Health program provide services which these children would not have obtained *(or would have obtained only after significant delay)* without Head Start?	LARGE EXTENT	MODERATE EXTENT	SMALL OR NO EXTENT
SCREENING TESTS			
MEDICAL HISTORY AND EXAMINATION			
MEDICAL TREATMENT			
DENTAL TREATMENT			
IMMUNIZATIONS			

VI. THE CONSULTATION PROCESS

14. In the course of your consultation did you

- ☐ MEET WITH COMMUNITY ACTION AGENCY DIRECTOR OR HIS REPRESENTATIVE
- ☐ MEET WITH HEAD START DIRECTOR
- ☐ MEET WITH HEAD START PARENTS
- ☐ VISIT A HEAD START CLASSROOM IN ACTION
- ☐ MEET WITH LOCAL MEDICAL SOCIETY OR ITS OFFICERS
- ☐ MEET WITH LOCAL HEALTH OFFICER OR HIS REPRESENTATIVE
- ☐ MEET OR TALK ON TELEPHONE WITH ANALYST OR FIELD REPRESENTATIVE IN OEO REGIONAL OFFICE

15. In which of the following ways were you able as a consultant to help?	MAJOR IMPACT	MINOR IMPACT	NONE
a. SOLICITING INTEREST AND PARTICIPATION FROM LOCAL PHYSICIANS			
b. IDENTIFYING AND ARRANGING FOR USE OF EXISTING HEALTH CARE SERVICES AND FUNDS			
c. OBTAINING INTEREST AND PARTICIPATION FROM LOCAL HEALTH AND WELFARE AGENCIES			
d. IMPROVING THE PLANNING PROCESS AND ORGANIZATIONAL PATTERNS			
e. SUGGESTING BETTER METHODS OF SCREENING, EXAMINING, TREATING OR PROVIDING HEALTH EDUCATION			

16. Give one example of how you, as a consultant, contributed to the Health Services Program of the grantee.

17. What is your estimate of the value of the consultation program in improving the quality of health care for Head Start children?

- ☐ WORTHWHILE AND SHOULD BE CONTINUED
- ☐ WORTHWHILE IF MODIFIED
- ☐ NOT WORTHWHILE AND SHOULD NOT BE CONTINUED

What modifications would you suggest?

Table 1. REPLIES TO QUESTIONS ON PLANNING OF HEAD START HEALTH PROGRAM

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Total reports submitted	33	100%	35	100%
Which of the following were substantially involved in planning the Head Start Program?*				
Health Department	19	58%	17	49%
Welfare Department	22	67%	27	77%
School Health Program	21	64%	24	69%
Medical Society	3	9%	3	9%
Pediatric Association	9	27%	4	11%
Dental Society	6	18%	7	20%
How successful was the health program in obtaining meaningful participation of all important community health resources in planning the Head Start Health Program?				
Very successful	11	33%	12	34%
Partially successful	13	39%	14	40%
Little success	9	27%	8	23%
No answer	-	-	1	3%
Did the plan for health services appear to be adequate to meet the health goals of Project Head Start?				
Superior plan	9	27%	8	23%
Adequate plan	16	48%	19	54%
Plan with inadequacies	6	18%	8	23%
Generally inadequate plan	1	3%	-	-
No answer	1	3%	-	-

*Sum is greater than total reports submitted because more than one agency was involved in planning.

Program

Table 2. provides data related to the five categories of questions asked about the program.

On the question of extent to which participating physicians were informed about the goals and guidelines of the Head Start Programs and their roles in it, the consultants' estimates indicated inadequate information for a range between 18%-29%. Otherwise, they were adequately informed 52%-49% of the time and very well informed 24%-23% of the time. These figures represent almost identical data when compared to the responses of 1967.

This year almost all children who were examined by a physician were private patients under the Medicaid Title XIX Program. Therefore, the positive evaluation of extensive concern for the dignity, comfort, and convenience of these patients would seem to reflect this factor. However, it is important to record that in communities where the Welfare Departments were reported as not processing doctors' bills promptly, some parents reported that "they were treated condescendingly" and would either prefer clinic arrangements or going to the private practitioner's office with other low-income parents. Parents, encouraged by Head Start Staff, generally were present at the time of the physician's examination as reported in the response 73%-86% -- almost universally so.

Consultants' responses to the question of whether health programs were scheduled as an integral part of the total child development program indicated a high degree of coordination. None were cited as being disruptive or interfering with other components of the program. More than half were cited as being well integrated and coordinated; that is, 58%-63%.

Pediatricians' and generalists' responses to the question of whether the health program was organized to insure continuing care by the examining physician indicated a variation in classifying those programs where this was minimally a factor. Pediatricians reported six such while generalists only reported two. On the whole, generalists indicated better results than did pediatricians. Generalists rated 94% of the programs achieving degrees of continuing care while pediatricians rated 79% in this category.

Table 2. REPLIES TO QUESTIONS ON PROGRAM OF HEAD START HEALTH PROGRAM

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Total reports submitted	33	100%	35	100%
Were participating physicians well informed about goals and guidelines of Head Start Health Programs and their precise role in it?				
Very well informed	8	24%	8	23%
Adequately informed	17	52%	17	49%
Inadequately informed	6	18%	10	29%
No answer	2	6%	-	-
Was the medical program carried out in such a way as to be convenient, comfortable and dignified for the children and parents? Did the participating physicians appear to be concerned about the dignity and comfort of the Head Start children and parents?				
Very much so	16	48%	20	57%
To a large extent	11	33%	10	29%
To only a small extent	3	9%	2	6%
No answer	3	9%	3	9%
Were parents present at the time of the physician's health evaluation?				
Almost universally so	24	73%	30	86%
Less often	7	21%	2	6%
Infrequently	-	-	1	3%
No answer	2	6%	2	6%
Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components?				
Well integrated and coordinated	19	58%	22	63%
Peripheral to rest of program but not disruptive	11	33%	13	37%
Scheduled so as to disrupt or interfere with other components of program	-	-	-	-
No answer	3	9%	-	-
Was the health program planned and organized so that children could obtain continuing care (during and after Head Start) from the physician examining and treating him in Head Start?				
To a great extent	19	58%	22	63%
To a moderate extent	7	21%	11	31%
To little or no extent	6	18%	2	6%
No answer	1	3%	-	-

Records

Table 3. reports the responses to three questions about records: (a) their adequacy as a basis for future treatment and supervision; (b) the existence of a checking device or system to insure that each child received screening and treatment; and (c) such record keeping and summaries that would be adequate for future programming.

Only 15%-14% of the records were noted as inadequate if used as a basis for future treatment. It is interesting to note that the generalists rated 57% of the record systems as very adequate in contrast to the 42% rating of the pediatricians. The former reported in narrative considerable effort spent in interpretation of this objective and in many cases actually distributed either the Office of Economic Opportunity Head Start Health Records or the Massachusetts School Health Records forms to the program director.

Generalists and pediatricians were in close agreement that checklists were utilized and were effective tools. Eighty-five per cent to ninety-one per cent of the programs had such, and they were adequate as reported in 89%-91% of the programs.

Perhaps the area for future improvement lies in the preparation of program statistics and summaries to serve as the basis for planning and budgeting of future health programs. Only 45%-51% of the programs were rated as adequate in this category.

Table 3. REPLIES TO QUESTIONS ON RECORDS OF HEAD START HEALTH PROGRAM

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Total reports submitted	33	100%	35	100%
Were individual health records of sufficient detail and quality to serve as a basis for all future treatment and health supervision?				
Very much so	14	42%	20	57%
Adequate	14	42%	10	29%
Inadequate	5	15%	5	14%
Was there a checksheet, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?				
*Yes	28	85%	32	91%
No	4	12%	1	3%
No answer	1	3%	2	6%
*Total - Yes	28	100%	32	100%
Did it accomplish its purpose?				
Adequately	25	89%	29	91%
Inadequately	2	7%	1	3%
No answer	1	4%	2	6%
Were health program records, statistics and summaries adequate to serve as a basis for realistic planning and budgeting of future health programs?				
Very much so	13	39%	15	43%
Adequate	15	45%	18	51%
Inadequate	5	15%	2	6%

Summary Evaluation

Table 4. summarizes how well programs achieved some of the health goals of Head Start. Although a record of "high success" might be construed as the ultimate goal, th actual achievements under this heading would seem to indicate the need for much more efforts.

The highest percentage of success in finding health defects was through screening tests and physicians' examinations. The use of past health records did not appear to have much relevance in finding defects.

Medical treatment of health defects was much more frequent than follow-up of dental or psychological needs. In some instances consultants reported on the difficulty of arranging for dental work within the space of an eight-week summer program. Some communities reported no available services for psychological referrals. These factors may explain the low scores on data reported.

In elaborating on the prevention of future health problems, it would appear that there has been very slight success in the use of fluoride dental treatment. Although high success was reported 58%-57% through immunizations, it falls far short of the goal of universal immunization. The degree of success in introducing the child to physicians for future care is reported as almost identical with that of introduction to dentists. The data seems to show, also, that health education as a means of preventing future health problems needs greater emphasis.

In reporting on the degree of success in improving the health of family members, the fact of introducing the family to sources of health care funds rated highest, 48%-51% -- high success.

Analyzing the responses to the question of improving the health of the community through stimulating new resources to provide and pay for child health care, and making existing resources more responsive to the special needs of the poor, we notice significant differences. Under the category "moderate success" and "slight success" there are marked differences between the ratings by generalists and pediatricians 33% vs. 11% "moderate success" for the first question and 39% vs. 17% for the second question, etc. It would appear that each consultant perceives community improvement goals somewhat differently.

Table 4. REPLIES TO QUESTIONS ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

	Degree of Success in Achieving Specified Goals									
	All Replies		High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
a. Finding health defects through:										
Teacher's observations										
Pediatricians	33	100%	15	45%	10	30%	6	18%	2	6%
Generalists	35	100%	17	49%	11	31%	5	14%	2	6%
Screening tests										
Pediatricians	33	100%	18	55%	9	27%	6	18%	-	-
Generalists	35	100%	21	60%	10	29%	3	9%	1	3%
Physician's examination										
Pediatricians	33	100%	15	45%	14	42%	3	9%	1	3%
Generalists	35	100%	20	57%	10	29%	4	11%	1	3%
Past health records										
Pediatricians	33	100%	7	21%	14	42%	10	30%	2	6%
Generalists	35	100%	9	26%	12	34%	11	31%	3	9%
b. Treating health defects										
Medical										
Pediatricians	33	100%	20	61%	8	24%	5	15%	-	-
Generalists	35	100%	21	60%	10	29%	3	9%	1	3%
Dental										
Pediatricians	33	100%	10	30%	14	42%	7	21%	2	6%
Generalists	35	100%	7	20%	18	51%	9	26%	1	3%
Psychological										
Pediatricians	33	100%	4	12%	18	55%	9	27%	2	6%
Generalists	35	100%	11	31%	14	40%	6	17%	4	11%
c. Preventing future health problems through:										
Immunizations										
Pediatricians	33	100%	19	58%	11	33%	3	9%	-	-
Generalists	35	100%	20	57%	10	29%	4	11%	1	3%
Fluoride dental treatment										
Pediatricians	33	100%	4	12%	5	15%	19	58%	5	15%
Generalists	35	100%	6	17%	7	20%	12	34%	10	29%
Health education										
Pediatricians	33	100%	10	30%	15	45%	7	21%	1	3%
Generalists	35	100%	10	29%	14	40%	10	29%	1	3%
Introducing child to physician who can provide future care										
Pediatricians	33	100%	12	36%	11	33%	8	24%	2	6%
Generalists	35	100%	14	40%	13	37%	7	20%	1	3%
Introducing child to dentist who can provide future care										
Pediatricians	33	100%	10	30%	13	39%	6	18%	4	12%
Generalists	35	100%	9	26%	14	40%	12	34%	-	-

Table 4. REPLIES TO QUESTION ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM--Con.

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
d. Improving health of family members by:										
Calling attention to family health needs										
Pediatricians	33	100%	14	42%	11	33%	7	21%	1	3%
Generalists	35	100%	14	40%	12	34%	8	23%	1	3%
Introducing family to sources of health care funds and services										
Pediatricians	33	100%	16	48%	11	33%	4	12%	2	6%
Generalists	35	100%	18	51%	13	37%	3	9%	1	3%
e. Improving the health of the community through:										
Increasing awareness of health problems of poor children										
Pediatricians	33	100%	15	45%	9	27%	7	21%	2	6%
Generalists	35	100%	13	37%	10	29%	11	31%	1	3%
Stimulating new resources to provide and pay for child health care										
Pediatricians	33	100%	5	15%	11	33%	13	39%	4	12%
Generalists	35	100%	9	26%	4	11%	17	49%	5	14%
Making existing resources more responsive to the special needs of the poor										
Pediatricians	33	100%	8	24%	13	39%	7	21%	5	15%
Generalists	35	100%	10	29%	6	17%	15	43%	4	11%

Impact

Table 5. records responses to the question, "To what extent did the Program provide services which these children would not have obtained without Head Start." The areas of screening tests and medical history were cited by generalists and pediatricians alike. Generalists further rated medical treatment and dental treatment as extensive.

Unfortunately reading the figures in the column "Small or No Extent" under the heading "Extent to Which Program Provided Services", we note that there are still too many programs falling into this minimal or missing category.

Table 5. REPLIES TO QUESTIONS ON IMPACT OF HEAD START HEALTH PROGRAM

	All Replies		Extent to Which Program Provided Services: Large Extent		Moderate Extent		Small Or No Extent		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
To what extent did the Head Start Health Program provide services which these children would not have obtained (or would have obtained only after significant delay) without Head Start?										
Screening tests										
Pediatricians	33	100%	20	61%	9	27%	4	12%	-	-
Generalists	35	100%	26	74%	7	20%	2	6%	-	-
Medical history and examination										
Pediatricians	33	100%	17	52%	11	33%	5	15%	-	-
Generalists	35	100%	24	69%	7	20%	4	11%	-	-
Medical treatment										
Pediatricians	33	100%	13	39%	13	39%	7	21%	-	-
Generalists	35	100%	21	60%	11	31%	2	6%	1	3%
Dental treatment										
Pediatricians	33	100%	15	45%	12	36%	5	15%	1	3%
Generalists	35	100%	22	63%	8	23%	5	14%	-	-
Immunizations										
Pediatricians	33	100%	13	39%	16	48%	4	12%	-	-
Generalists	35	100%	13	37%	15	43%	5	14%	2	6%

The Consultation Process

Table 6. analyzes the data recorded. As we would expect, 100% of the consultants reported involvement with the Head Start Director. From the way in which the question was worded, this is not to be construed as an individual conference. The community action agency director was involved in 64%-51% of the consultation. Although classroom visitation was not required, 57% of the generalists and 45% of the pediatricians visited them. Contacts with the analyst or field representative of the Office of Economic Opportunity regional office were reported infrequently -- by 21% of the pediatricians and 11% of the generalists. Since this was not a routine procedure, we cannot make any assumptions about which party took the initiative to make such contacts.

In reporting on the degree of impact of consultation, once again we note very little involvement with local physicians. Only 14% of the generalists and 45% of the pediatricians had any impact at all. In the matter of arranging for the use of health care funds and services as well as obtaining the participation of local health and welfare agencies, these would seem activities more appropriately initiated by the Head Start Program. The high rate of responses of either minor or no impact by both consultants seems to substantiate this.

In view of the fact that one of the most-mentioned suggestions for modifying future programs would be to involve consultants earlier in the planning stages, the responses to impact on improving the planning process reflect consistency. Pediatricians recorded minor or no impact in 57% of the cases; generalists, in 71%.

The pediatricians and generalists in giving their estimate of the value of the consultation program for improving the quality of health care for Head Start children rated it as worthwhile with only five exceptions. However, in examing the tally for worthwhile with modifications or with no qualifications, we find almost reversed correlations.

Pediatricians rated 30% in need of modifications and 64% in need of no changes while generalists would appear to have greater reservations about the program. They rated 57% in need of modifications and only 34% in need of no changes.

The dynamics of the development of effective consultation cannot appropriately be judged by the questions contained in the evaluation schedule (CAP-HS Form 48). In order to try to document some dimensions of staff involvement in this area, the Advisory Committee drafted a report form for use by the public health generalists. (A copy appears in the Appendix.)

A review of these reports for individual communities from a chronological viewpoint reveals the pivotal role of the public health generalists as catalysts for building continuing relationships with Head Start staff.

Copies of the pediatric consultant reports were forwarded monthly to the Washington and Regional Office of Economic Opportunity Offices.

Table 6. REPLIES TO QUESTIONS ON THE CONSULTATION PROCESS OF HEAD START HEALTH PROGRAM

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Total reports submitted	33	100%	35	100%
In the course of your consultation did you				
Meet with community action agency director or his representative	21	64%	18	51%
Meet with head start director	33	100%	35	100%
Meet with head start parents	12	36%	9	26%
Visit a head start classroom in action	15	45%	20	57%
Meet with local medical society or its officers.	3	9%	3	9%
Meet with local health officer or his representative	15	45%	7	20%
Meet or talk on telephone with analyst or field representative in OEO regional office	7	21%	4	11%

	All Replies		Degree of Impact of Consultation: Major Impact		Minor Impact		None		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
In which of the following ways were you able as a consultant to help?										
Soliciting interest and participation from local physicians										
Pediatricians	33	100%	4	12%	11	33%	16	48%	2	6%
Generalists	35	100%	1	3%	4	11%	26	74%	4	11%
Identifying and arranging for use of existing health care services and funds										
Pediatricians	33	100%	9	27%	16	48%	7	21%	1	3%
Generalists	35	100%	6	17%	12	34%	13	37%	4	11%
Obtaining interest and participation from local health and welfare agencies										
Pediatricians	33	100%	4	12%	14	42%	13	39%	2	6%
Generalists	35	100%	6	17%	12	34%	15	43%	2	6%
Improving the planning process and organizational patterns										
Pediatricians	33	100%	11	33%	15	45%	4	12%	3	9%
Generalists	35	100%	8	23%	21	60%	6	17%	-	-
Suggesting better methods of screening, examining, treating or providing health education										
Pediatricians	33	100%	13	39%	13	39%	4	12%	3	9%
Generalists	35	100%	9	26%	17	49%	6	17%	3	9%

Table 6. REPLIES TO QUESTIONS ON THE CONSULTATION PROCESS OF HEAD START HEALTH PROGRAM--Con.

	Reports Submitted By: Pediatricians Number	Pediatricians Per Cent	Generalists Number	Generalists Per Cent
Total reports submitted	33	100%	35	100%
What is your estimate of the value of the consultation program in improving the quality of health care for Head Start children?				
Worthwhile and should be continued	21	64%	12	34%
Worthwhile if modified	10	30%	20	57%
Not worthwhile and should not be continued.	2	6%	3	9%

Copies also were sent to Head Start Program Directors. Therefore, we will not recapitulate this data here but will try to give a brief overview of accomplishments recorded by the public health generalists which have not been summarized elsewhere.

At the outset, generalists spent a great deal of time interpreting the goals of the consultation program to the Head Start Director and staff. Thereafter, the generalist was responsible for making the myriad of telephone and written contacts with all concerned for setting up group consultation sessions. (This was reported as a very time consuming chore -- to determine a mutually convenient meeting time for at least a half dozen and often many more conferees.)

Thereafter, the generalist was always available for consultation on request. In communities where programs needed strengthening or assistance, many additional visits were made to review records, visit classrooms, assist in procuring the services of specialists, note progress, and provide support for continuing follow-up. (The formula for visits by pediatric consultants as set in the contract included two visits to summer programs, three visits to year-round programs, and four visits where the community action agency sponsored both a year-round and summer program.)

Largely because of the suggestions and assistance of generalists, a great variety of community agencies became involved in giving service. These agencies had not been approached before the project proposals were submitted. Examples of these included the Massachusetts Association for the Prevention of Blindness which trained volunteers and others to do vision testing; university dental school clinics, local hospital technicians and nursing students, and nurses from local health departments were all solicited to provide specific services. The Regional Health Office Staff of the Massachusetts Department of Public Health provided nursing, nutrition, and dental hygiene consultation to newly-employed staff. Arrangements were worked out to incorporate spring preschool examinations into the examination schedule. Local health departments were encouraged to cooperate more fully in providing required immunization and tuberculin testing.

There were other dimensions of the consultation program effect not touched on in the evaluation schedule. They included contact with a wide range of Head Start workers. In addition to the Community Action Program Director, the Head Start Director, the Medical Director and the nurses, they included parents, educational or social service supervisors, parent aides, health aides, case aides, psychologists, food service staff, and volunteer workers. Among the reasons given for the extent of generalists' involvement was the dedication and enthusiasm of Head Start Staff. This feeling-tone is repeated again and again by both pediatricians and generalists.

Item #10 on the Public Health Generalists' Report form asks for a listing of the "Specific Contribution of the Generalist" in the contact being recorded. We quote verbatim from some of these reports the statements which reflect on the dynamics of the process.

"To plan a system of communication"

"Improved the climate for consultation team meeting and for more productive relationships"

"Encouraged better record keeping"

"Opened up communication;"

"Fostered working relationships with the team"

"Listened at great length to problems; assisted in revising plans for new approaches."

"Continuity of Planning"

"Involved Head Start staff in participation for planning"

"Interpreter, coordinator, convener"

"Guided and coordinated planning"

"Supportive role"

"Leader of group conference"

"Encouraged follow-up"

"Chaired meeting"

The analysis of <u>suggested modifications</u> in response to the "open-ended" section of question #17 follows.

Table 7. ANALYSIS OF RESPONSES TO SUGGESTED MODIFICATIONS

Suggestion	Reports Submitted By: Pediatricians	Generalists
Earlier involvement in planning	11	15
Provide additional personnel	4	2
Appoint a medical director		
Employ a nurse		
Secure more community involvement	6	6
(e.g., Local Health Department, the dental community)		
Modify the "Team"	2	2
Use only 2 people-MD and P.H.N.		
Use traveling teams of experts		
Fewer consultants seeing more places		
On-call expert teams		
Orient Head Start workers to health program goals	3	5
Develop pediatric clinics	2	2
Establish continuity by use of the same consulting team	1	1
Educate the membership of the medical society and the American Academy of Pediatrics to program objectives	-	1
Good program needs only:	-	3
Telephone conversation		
One or two visits		
Visits on a selective basis		
Change the frequency of consultation visits	3	1
Provide more uniformity of record keeping.	2	-
The consultant physician should come from the same community	1	-

Consultant Contributions

(As reported by public health generalists and pediatric consultants serving the same programs.)

KEY: 1. is the response of the pediatrician.
2. is the response of the generalist.

Community A

1. *"Suggested approaching auto dealers to supply free car and driver once or twice a month to transport mental health and physical follow-ups to various health centers."*
2. *"My main function was (with the pediatrician) to make sure of the health focus of the program plus in-service training, mid session evaluation."*

Community B

1. *"I suggested that at the time of enrollment parents sign a statement authorizing the Head Start physician to examine their child if they failed to have an examination performed within a reasonable time."*
2. *"Serving as a good 'listener' and stimulating staff to be more analytical and to express their opinions of current practices and to volunteer suggestions for improvements. This preparation led to more discussion at the team evaluation meeting."*

Community C

1. *"My being there (as an evaluator) served to make the staff review its methods and efficiency and helped serve to keep its members on their toes. I suggested greater effort toward cooperation with the various churches and stimulating a more active interest on their part. They might help in providing sitters so that parents could attend more educational programs during the summers (these are better attenced during the winter)."*
2. *"Assisted new nurse in setting priorities during the last three weeks of the program."*

Community D

1. *"Suggested flagging the health records which the school nurse should be aware of so that they would not be overlooked. Encouraged closer relationships between Head Start Health Programs and School Health Programs."*
2. *"Encouraged Head Start Health Staff to involve other community health agencies such as school health and welfare for planning Head Start programs. Encouraged strengthening relations between Head Start Staff and Health and School Departments especially regarding planning health programs. Providing services, follow-up of children and families with health needs."*

Community E

1. *"Identifying or at least focusing on public schools as sources of recent physical examination report and forthcoming source of vision testing, immunizations, hearing testing and even physical examination if need be for those who have not already been examined. Attempted to relieve a sense of frustration by suggesting that the issue of 'health' was enormously broad and that if certain families were at least made aware of medical facilities - that if staff could penetrate social barriers, etc. they should not feel that all was failure because, for example, hemoglobin determinations were spotty, particularly when the medical community wasn't so certain hemoglobin determinations were of paramount importance in white children in Northern cities."*
2. *"Met with Head Start Director (prior to Head Start Program), suggested names of potential nurse candidates for the program, assisted new nurse in planning health service program, provided list of other health resources for health screening, etc. and was available for consultation as needed."*

Community F

1. *"I called their attention to problems of last year, reminded them that continuity of personnel was important. Furthermore, I talked to them about what a good program did, how it functioned, how they could emulate this program."*
2. *"Arranged for the C___ Agency to contract with the VNA to coordinate and implement the health component. An excellent job was done. Assisted in the coordination of VNA, Health Dept. and delegate agency director to work together."*

Community G

1. *"The entire health program is inadequate. I emphasized the need of adequate pre-admission physical examinations and screening tests. I stressed the need for cooperation between 'Head Start' and the Local Health Director. There is a pressing need for a local medical director and funds for this position."*
2. *"It was recommended that Head Start apply to OEO for funds to pay medical consultant who could discuss health problems with Head Start team as they arose."*

Community H

1. *"The dental aspect of this program should be strengthened by returning a dental hygienist to the program to do the service and re-emphasizing steps which are necessary to get a dentist involved. Perhaps the answer would be to request a part-time dental director who would receive a fee for his service the same as a part-time medical director does."*
2. *"Stressed the importance of using the skills and experience of the Public Health Nurses of the F_____ Nursing Association rather than using the mother of one of the children (a Registered Nurse employed as a Neighborhood Aid) for making decisions and assuming responsibility for Head Start Program health aspects."*

Community I

1. *"Mental Health follow-up difficult because of lack of transportation to distant facility. Suggested they follow the procedure of other large cities, namely, contact one of the auto dealers in town and ask him to supply free of charge a car and driver to transport these youngsters once or twice a month."*
2. *"Participated in pre- and in-service training periods with entire staffs. Discussed main outlines with just directors and head teachers in separate meetings and met at mid-session evaluation program."*

Community J

1. *"Medical Director should be used to help plan the programs and review the completed health forms. Local Tuberculosis Association should do tuberculin testing on all children. Physical examination, immunizations and laboratory tests should be completed before the end of classes so they can complete and organize any further care needed. All information gathered by the case worker should be sent to the family doctor with the examination forms."*
2. *"Communication was a major problem throughout this program. In less than two months I met with various members of the team at least seven times. Through organized meetings, as well as telephone communication I felt I was able to help the program staff to better identify the roles and responsibility. Communication with and between the physicians was a major feature of the general communication problem. Through my time and effort the program staff identified this problem and arranged a meeting with the medical director to candidly discuss the problem hopefully."*

Community K

1. *"The reliance and respect shown for the Pediatric medical director was rewarded with the genuine investment by the latter who acted as physician, consultant, referral agent and evaluator of each child. Such shortcomings in the health program, i.e., more detailed involvement of mental health consultant, educational opportunities of health and nutrition were relatively minor compared to the generally good scores."*
2. *"The role of the consultant was more one of encouragement and support. The need for more participation of the community in planning for dental care was stressed."*

Community L

1. *"Screening tests for TB were not done by the examining physicians, so I obtained TB Tine Tests from our Local Health Dept. and instructed the nurses how to administer the test."*
2. *"Recommendation that separate grantees write project applications for the two areas that are included in common planning for Head Start. This area comprises hill towns and is very rural. Master planning is done for this area as well as an urban center. Problems are not the same. Separate projects should be written."*

Community M

1. *"Recommended the need for Medical Director to facilitate the return of examination forms most of which are still outstanding, as well as to settle various major and minor medical questions that have arisen. Suggested the desirability of budgeting a mutually agreeable sum for a Medical Director; suggested an early appointment, turning over the entire medical program to the Medical Director for early planning, asking him for an early report at a meeting, and using the nurse for continued close cooperation and liaison bilaterally."*
2. *No comment.*

Community N

1. *"There does not seem to be a real involvement and interest of the medical community here in the CAP and Head Start Program. Suggestions were made on who and how this may be accomplished. Specifically it was suggested that the local medical society be addressed by one or two members of the program and the regional representative of the Academy of Pediatrics be contacted in order to bring the Academy of Pediatrics resources to bear."*
2. *No comment.*

Community O

1. *"Suggesting better orientation of participating M.D.'s."*
2. *"Attempted to arrange for use of audiometer and qualified person to operate it."*

Community P

1. *"Improved means of communication between families and programs by suggesting use of Community Action Group in community to overcome problems inherent in language barrier (Spanish) of appreciable number of children of families in program. Clarifying relationships between agencies involved and help them with what may have varied from praise for a job well done or some suggestion for implementing a Head Start suggestion. Letter to Mayor and Board of Health favoring fluoridation of water."*
2. *"Encouraged early enrollment of Summer Head Start pupils and early implementation of health exams, etc. even before program actually started. Use of case aides to do screening procedures under and with nursing direction."*

Community Q

1. *"Because of the delay in payment for Medicaid (6 to 9 months), a problem is created here inasmuch as the doctors are willing and the dentists are willing to serve but their interest is waning a bit. I think if they could be paid for their services, the doctors and dentists would be very glad to cooperate as they seemed interested in conscientious people."*
2. *"By meeting with the Head Start Nurse and offering suggestions as to possible methods of obtaining the base line health information at an earlier date, to facilitate program planning and implementation."*

Community R

1. *"With Medicaid there is little medical care provided. If the parent doesn't go to M.D. or can't find one, there isn't any health care. Recommendation was made to the director of the program that the school department be encouraged to have it mandatory that all children entering school for the first time have a complete history and physical. The recommendation that the Public Health Dept. be involved in the planning, if at all possible, and perhaps when the clinic which Dr.____ is establishing, is in continuous operation, it might be used for those patients who have not seen their doctor or do not have any doctor during the summer months when their children are attending Head Start."*
2. *"Provided supply of house records."*

Community S

1. *"I spoke at length to the Medical Director about adequate screening by qualified physicians. At present most children get only immunization and are observed fully clothed as to gross abnormalities. This is, of course, inadequate. The parents at present have to take their children for examination and in the next year there's going to be greater stress on this to get 100% participation. I stressed the importance of screening examination and they are going to go all out in this effort."*
2. *"Consultant did a good deal to acquaint the agency with good standards for a school health program."*

Community T

1. *"Talked with the physicians who did the screening examinations. Also talked with the dentist but was not so successful in getting his cooperation."*
2. *"Due to a misunderstanding the children of this year's Head Start were not examined by a dentist. As consultant, I got in touch with the _____ health district and was instrumental in making arrangements to have the Head Start children now in kindergarten examined by a dental hygienist by the Dept. of Health. Arrangements were made with Miss _____, the school nurse, to do any necessary follow-up."*

Community U

1. *"This program appears to be functioning well. Screening tests are being performed, local agencies are cooperating, as well as the physicians who are caring for the children during the summer as well as throughout the year. Continuing dental care appears to be the major problem, but it can be partially solved by the local dental clinic. I encouraged them to continue their good work."*
2. *"Re-enforced the excellent work of the Head Start Program and staff, particularly the school nurse and the director."*

Community V

1. *"Letter to go out next year to community physicians explaining the function of the program, from the Medical Director."*
2. *"Suggested Medical Director of Local Head Start Program send informational letter to all members of the medical community to better orient physicians to the total goals of the health component of Head Start Programs."*

Community W

1. *"The dental program was in arrears and the suggestion was made that it needs more aggressive planning and commitment."*
2. *"Program was well planned and off to a good start before consultant service was available so that the role was one of support and encouragement in assistance to bring out the need for more community participation and planning."*

Community X

1. *"I have been fortunate in having been assigned to a well organized interested group administering Head Start in _____. The program as a whole was more than adequate in its total worth to the community. I have served as a supportive member of the group in having encouraged participation of parents in the program. I have stressed the need to counsel parents along with their children so as to approach the family as a unit."*
2. *No comment.*

Community Y

1. *"Urine analysis was not done on the majority of the children. Nor was the local hospital laboratory willing to do them. I provided the Director with sufficient material for at least the sugar determination. Suggested the use of service clubs to provide vision and hearing tests."*
2. *"Since this program operates in four somewhat rural communities, dental services are not readily available. I suggested that the Department Dental Hygienist was available on request to present a Dental Education Program and to make an examination to determine the need for dental referral. This service was very helpful to the program."*

Community Z

1. *"Encouragement that <u>all</u> aspects of the summer program, healthwise, are important and should be met."*
2. *"I feel that because of the involvement in the Year-Round Program we had an opportunity to have more impact on the Summer Program. We offered suggestions regarding nutrition - having a nutritionist from the Dept. of Public Health meet with the staff. In one center children were not eating well at noon. Advised not to give children such a large snack at 10:30 and to give snack earlier. Records improved. Comprehensive health record for each child. Participants in programs very dedicated, however, recommended that they should more actively involve local health agencies in program so that they too feel responsibility for results."*

Community AA

1. *"In the meeting suggesting a better method of contacting and alerting participating physicians of their roles. Suggesting to the director a meeting of consultants to iron out liaison problems."*
2. *"Arrangements for use of audiometer and qualified person to operate it."*

Community BB

1. *"Suggested approaches for raising funds. Attempted to procure positions and medical directors. Established an immunization program. Verified follow-up care and consultation."*
2. *"Through the cooperation of a staff member of Child Growth and Development Unit I was able to arrange training sessions in the use of the audiometer for interested mothers and neighborhood aids. Hopefully this will accomplish several objectives of the Head Start Program: 1) involvement of parents in providing for the health needs of their children, 2) assuring that all children have the benefit of audiometric testing in future programs, and 3) release professional for more meaningful participation in the Head Start Program."*

Community CC

1. *"Recommended that screening tests for vision and hearing and laboratory tests should be completed before the physical examinations to enable the examining physician to discuss all referrals with the mothers."*
2. *"Advised to employ the services of a psychologist to observe and spot problem children in the classroom. Following his observation the psychologist should meet with the teachers and social workers to be given instructions in the management of children with minor behavioral and emotional problems. Provided information about in-service training of case aids and teacher aids. Suggestions to enable the case aid to have special training and special courses (also mothers in the group). Encouragement for _____ to consider a year-round Head Start Program."*

IV. SUMMARY AND RECOMMENDATIONS

The contributions of health services Consultant Teams made available to each year-round and summer Head Start Program in the Commonwealth of Massachusetts are described in this report. The Massachusetts Project emphasizes the inter-disciplinary approach whereby a constellation of professionals can help to develop a system for involving other health professionals and community agencies to serve children and their families. Such a program might serve as a model for community participation in child health programs.

It takes effort, time, and continuity "to build bridges" and maintain them between the team members, as well as between the consultation team and the staff of the Head Start Programs. We have recorded the logistics of planning, involvement, and an evaluation of program results. Statistical data are based on the analysis of sixty-eight completed evaluations (CAP-HS Form 48) for summer programs.

A high level of professional interest and concern has been recorded on the part of those who became involved in the Consultation Program. From material furnished in the reports of these professionals and other administrative considerations, we submit the following recommendations for strengthening and improving continuing programs:

RECOMMENDATIONS

In relation to the medical and dental areas:

1. *Greater involvement by local medical and dental societies. This will require greater effort in interpretation of Head Start Program goals and the role of Medical and Dental Society members in achieving these goals.*

2. *Provision of medical guidance where none is currently available in certain local programs.*

3. *The preparation of a standard definition of the role of the medical consultant and the role of the medical director.*

4. *The provision of community resources for the treatment of dental disease and of mental and emotional problems in communities where these are lacking.*

5. *Encourage fluoridation of municipal water supplies.*

6. *A review of the contributions of pediatric clinics and private practitioners in providing quality health examinations.*

In relation to the public health generalists:

1. Change the title "public health generalist" to "public health consultant."

2. Stabilize the relationship of the Consultant Team as a continuing, advisory committee available at all times to Head Start Staff. This would encourage earlier involvement in the planning of health services and better understanding of team role.

3. Strengthen relationships with the Office of Economic Opportunity Regional Office.

4. Place greater emphasis on coordinating Head Start Health Services with those of other community health agencies, and better utilization of professional health personnel.

5. Expand and improve health education materials and health teaching for children, parents, and staff.

In relation to Office of Economic Opportunity administrative procedures:

1. Correlate and make statistical evaluation data available for local program planning, e.g., information from CAP-HS Form 48 and Form 64.

2. Provide for availability of published health services materials to all who are involved in health services planning. For example, we may cite the limited distribution of the "Health Bookkeeping System," the Health Record Form, and enrollment figures.

3. Develop a method of funding to ensure continuity of planning and services at all levels.

4. Provide a greater allocation of funds for employment of competent personnel by those communities unable otherwise to obtain such staff.

5. Develop a medium for exchange of news and ideas about program developments.

6. Strengthen communication linkage between federal, state, regional, and local staff.

Appendix A

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

Dear Doctor

In order to establish some uniformity in method of payment for Pediatric Consultation to the Head Start Program, we are adapting the method of payment used by the American Academy of Pediatrics as follows:

1. Travel allowance will be permitted at the rate of 8½¢ per mile.

2. An honorarium not to exceed $100 per day to be figured on an hourly basis of $12.50 per hour. The hourly basis for this honorarium should include travel time.

3. A per diem allowance over and above the honorarium will be permitted at the rate of $4 00 per 6-hour period. This per diem is allowed only in relation to field trips and should include time spent in travel as well as actual consultant time.

4. Payments for time spent in preparation of reports will be based on the $12.50 per hour rate.

This method of payment supercedes the method described in our recent letter and obviates the necessity of submitting a bill on your own letterhead. In order to facilitate payments under this method, we have devised a "Payment Voucher Form" which should be completed after each visit along with your pediatric consultant's report and submitted to

M. Grace Hussey, M.D., Director
Department of Public Health
Division of Maternal and Child Health Services
88 Broad Street
Boston, Massachusetts 02110

A supply of these forms is enclosed.

Sincerely yours,

M. Grace Hussey

MCH/srw
7/68-100

M. GRACE HUSSEY, M.D.
Director

Appendix B

MASSACHUSETTS HEALTH RESEARCH INSTITUTE, INC.

HEAD START PROGRAM

PEDIATRIC CONSULTATION SERVICE
PAYMENT VOUCHER FORM

TRAVEL

Automobile: Miles____ x 8.5¢ per mile $_____

PER DIEM

$4.00 per 6 hour period (not to exceed $16.00 per day)

No. of 6 hour periods_____ x $4.00 _____

HONORARIUM $100.00 per day (or $12.50 per hour)

No. days _____ x 100.00 _____

No. hours _____ x 12.50 _____

PREPARATION OF REPORT

No. hours _____ x 12.50 _____

GRAND TOTAL _____

I certify that the services described above were rendered during time for which I was not compensated by the Commonwealth.

FOR OFFICE USE ONLY

PAY _____

_____
authorized signature

Signature _____

Name _____
Please Print

Address _____

_____

PLEASE FORWARD TO

Dr. M. Grace Hussey, Director
Division of Maternal and Child Health Services
Room 518 - 88 Broad Street
Boston, Massachusetts 02110

7/68 - 500

Appendix C

CONSULTANT'S REPORT - HEAD START

1. NAME OF PEDIATRIC CONSULTANT: _____

2. ADDRESS: _____ _____ _____ _____
   Street City State Zip

3. PHONE NUMBER: _____ - _____ - _____
   Area Code

4. NAME OF GRANTEE _____; CITY _____

5. DATE OF CONSULTATION ACTIVITY: _____

6. HOURS SPENT: _____

7. NATURE OF ACTIVITY (SITE VISIT, MEETING, TELEPHONE CONSULTATION, ETC.): _____

8. PURPOSE OF CONSULTATION: _____

9. PROBLEMS ENCOUNTERED OR FORESEEN: _____

10. ACCOMPLISHMENT: _____

11. RECOMMENDATIONS AND REMARKS: _____

(Use additional sheets if necessary)

I AGREE THAT I SHALL NOT BE ENTITLED TO AND SHALL NOT CLAIM COMPENSATION FOR SERVICES PERFORMED UNDER THIS CONTRACT FOR ANY HOURS OF A WORKING DAY FOR WHICH I HAVE RECEIVED OTHER COMPENSATION AND THE SOURCE OF SUCH OTHER COMPENSATION HAS BEEN UNITED STATES PROVIDED FUNDS. FOR THE PURPOSE OF THIS CLAUSE PAYMENTS BY AGENCIES OR ORGANIZATIONS FUNDED BY GRANTS FROM THE UNITED STATES SHALL CONSTITUTE COMPENSATION FROM UNITED STATES PROVIDED FUNDS. IT IS FURTHER AGREED THAT ANY CLAIM FOR COMPENSATION SUBMITTED IN VIOLATION OF THIS CLAUSE SHALL, IF PAID, BE RECOVERABLE BY THE MASSACHUSETTS HEALTH RESEARCH INSTITUTE.

_____
Signature

_____
Date

Reimbursement for consultation is contingent upon prompt return of this Report.

Appendix D

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

June 21, 1966

Our Massachusetts Contract has just recently been negotiated so that we may plan health consultation to Summer Head Start Programs. Two visits are authorized.

With the help of Dr. Allan Stimson we have tried to plan for assignment of pediatric consultants to Head Start Programs which are within reasonable travel distance yet outside their own geographic area of practice.

We should like to ask that you serve as pediatric consultant to the Head Start Program in Our Public Health Generalist

will be getting in touch with you to arrange for a consultation team visit. She will provide you with a profile of the local Head Start Program which will be helpful to review prior to your first consultation visit. A representative from the Departments of Public Welfare and Mental Health will also participate.

We are enclosing four copies of the Consultant's Report form. Will you please complete one after each visit. Then, on your own letter-head, bill us for consultation services provided, and sign the bill. Both items should be mailed to this office.

Mrs. Hedwig Sorli, Coordinator, Head Start Project, and I will be glad to be of any possible help to you and the consultant team. You may reach us at this office (Tel. 727-5142).

We do appreciate your ready willingness to participate in this program.

Sincerely yours,

M. Grace Hussey

MGH/d
Enc.

M. Grace Hussey, M.D.
Director

Appendix E

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

MEMORANDUM

To: Head Start Pediatric Consultant

From: Dr. M. Grace Hussey

Date: July 26, 1968

Subject: Medical Consultant's Evaluation Form (Head Start)

The Medical Consultant's Evaluation of Head Start Health Services Form (copies enclosed) has just been received by us from the Office of Economic Opportunity. The O.E.O. requires that it be completed as part of the Massachusetts Program, as well as in the program of the American Academy of Pediatrics.

Will you please complete this form and return it to this office. It is to be completed at the end of the Head Start Program year — whether summer only or Full-year programs. If the program to which you provided consultation has terminated, will you please complete and mail the form as soon as possible. For most summer programs a final evaluation visit is still pending, and completion of the form will be delayed until this final visit.

We appreciate your continued cooperation.

Appendix F

HEAD START

PHASE II - SUMMER PROGRAM

Kit Contents

Left pocket of folder: (Basic material)

1. Memorandum on Contacts for Head Start Consultation (Yellow)
2. Suggested Guidelines for Public Health Generalists (yellow)
3. Head Start Project Profile (4 copies)
4. Memorandum regarding Program Profile (6/7/68)
5. Public Health Generalist's Report (6 forms enclosed) and Guide to Use of Public Health Generalist's Report

Right pocket of folder: (Supplementary material)

6. Health Goals of Project Head Start (blue)
7. Who Is Responsible for the Health of the Head Start Children? (green)
8. Planning Checklist for Head Start Health Services (pink) from "Project Head Start Health Services -- A Guide for Project Directors and Health Personnel"
9. Suggestions for Evaluation of Dental Program
10. Child Health Record Forms
11. Statistical Report - Head Start Program (Health Services)
12. Health Program Class Register
13. Pediatric Consultant's Report - Head Start
14. Declaration of Need for Medical Assistance (Form SS-37) (Rev. 11/67)

June, 1968

Appendix G

M E M O R A N D U M

To: Public Health Generalist Participants in Phase II of Head Start Consultation (Summer, 1968)

From: Hedwig Sorli
Coordinator, Head Start Program

Date: June 18, 1968

Attached is the Kit of "Head Start" materials. It includes four copies of the Profile of the Head Start Program to which you will be providing consultation. One is for your use; the others are for you to transmit before the initial "Team" visit to the consultants who will work with you: specifically, a pediatrician, a representative of the Department of Public Welfare, and whenever available, a representative of the Department of Mental Health. The memorandum from Miss Nan McGuire explains the reason for seeming inadequacies in the Profile content.

We would hope that you might make a personal visit to the Director of the local Head Start program before the Team visit. Our Head Start Advisory Committee suggested such a preliminary conference in order to help dispel any confusion about the consultation process, to make the acquaintance of staff, to assure participation by the local program Medical Director, and to interpret the nature and purpose of the Consultation Program in a friendly, non-authoritarian way. It was also suggested by the Advisory Committee that Public Health Generalists arrange a personal meeting with the assigned pediatric consultant, if possible, in advance of the Team visit.

Reporting

Please, record every activity in behalf of your program on the enclosed form entitled, Public Health Generalist's Report. We hope this will be an easy way to indicate the extent and type of service unique to Team Consultation for the final Project report. (The OEO Evaluation Forms have not yet been received. We will send them when they arrive).

PLEASE, SEND THE CARBON COPY OF EACH REPORT to us here in the Division of Maternal and Child Health Services.

Supplies

If you need any additional materials or forms please let us know.

Assistance

If you have any questions or problems, please feel free to communicate with us. We have experienced resource staff available and active participation by the Head Start Committee of the Massachusetts Chapter of the American Academy of Pediatrics.

Appendix H-1

HEAD START

Suggested GUIDELINES for Public Health Generalists

Introduction:

The purpose of the three Regional Conferences on Head Start held in January, 1968, was to evaluate the experiences of the Health Program Consultant Teams in 1967 and to look ahead to the provision of similar, but improved consultation to the Year Round and the Summer, 1968 Head Start Programs. It was also suggested that we establish an Advisory Committee to the new Massachusetts Project. This Committee set as its first task the development of the material which follows. You might like to add it to the notes which you may have made for your own purposes after the Regional Conferences.

We have tried to underscore areas of high priority, to suggest procedural outlines, and to re-define project goals, while providing specific facts about Massachusects programs.

It is anticipated that the Massachusetts programs (Year Round and Summer) will be funded by the Office of Economic Opportunity through the Massachusetts Health Research Institute, Inc.

Purpose:

To provide health consultant teams to sixty Head Start Programs in Massachusetts.

Consultation-days by teams will be provided as follows:

for 37 communities with only summer programs - 2 days

for 12 communities with full year programs - 3 days

for 11 communities with full year and summer programs - 4 days

The Health Goals of Project Head Start remain unchanged from their basic definition of 1967 (see Kit). This means that you might like to review the " Guide for Project Directors and Health Personnel" which was sent to you last summer.

The role of the team (briefly) is to:

a. Provide technical medical, dental, and related advice on the content and organization of Head Start Health Services Program.

b. Aid in securing the fullest utilization and mobilization of community funds and services to provide health care for head start children.

c. Plan for continuity of care and concern as Head Start children transfer to school programs.

Appendix H-2

d. Evaluate the effectiveness of the Health Services Program in meeting Head Start Goals.

The Public Health Generalist will serve as liaison to contact and mobilize the Consultation Team, to schedule field visits, to maintain communication with all involved (by telephone, letter or otherwise) in the community to which he is assigned. (Further amplification of the role of the Public Health Generalist is contingent on analysis of the information to be compiled by a new record keeping system.)

Problem Areas:

1. Has a high level administrator from the local school department been contacted and involved in consultation to the local program in order that the practical matters of continuity of record keeping between Head Start and the school department be explored, that follow-up of remediable defects be assured, that the possibility of program over-lap and duplication be kept to a minimum? The method of contacting and involving the local school system will of necessity vary from community to community; however, we urge the Generalist to suggest this type of contact be made at the outset of the consultation effort.

2. It is the responsibility of the Public Health Generalist to contact the pediatrician, the representatives of the Departments of Public Welfare and Mental Health and Dental Health as needed and the local Head Start Director. However, the local Head Start Director should be able to invite to the consultation meeting at least the following: the local program's medical and dental consultants, a representative of parents' groups, of the local health department, local welfare department and of the local school department. (In 1967 local health departments were involved very seldom...surely they have a responsibility to assist in developing more adequate local programs.)

3. The importance of obtaining and naming a health services director for each local program should be emphasized. Interpretation of the value of this type of leadership can be done both by the Generalist as well as the medical and/or dental consultants.

4. If the local Health Services Program as it was described in the original application was radically altered by the regional OEO office before it was funded and there is no written description of the funded program...the Generalist might encourage the preparation of a written statement describing it.

5. The responsibility for supervision of follow-up procedures should be clearly assigned, and the sustaining agency named. It may be necessary to interpret the reason for a public health nurse to assume this function; and even to investigate community agencies which might assist if funds are not available in the local Head Start Program Budget. Follow-up procedures and services are in need of great improvement. (We have included in the Kit a sample statistical report form developed in the Northeastern Region.

Appendix H-3

If the required figures can be entered in the appropriate spaces for a given program, the consultant can readily make commendations or recommendations. It has proven an effective device for objective review of a program's strengths and weaknesses in the absence of other summary record keeping.)

Several factors can influence treatment for correction of defects

> "The examining physician must explain the nature of the defect to the parent, along with the reasons for treatment and the kind of treatment needed. Someone must aid the parent in finding the needed service, and provide funds to pay for the services. Someone - nurse, social worker, or volunteer - must see that the parent and child actually have transportation and that other children in the family will be cared for during the visit to the physician or clinic. Someone must carefully and repeatedly screen records to assure that recommended treatment has actually taken place. No single measure will suffice; a program must be willing to do <u>whatever is necessary</u> to assure treatment and follow-up." *

6. Is there provision for dental services - preventive, therapeutic and educational?

7. Records and forms -

> Is there a plan for routing individual health records?
>
> Are teachers encouraged to record and report their health observations?

8. Is there a plan for handling emergencies, as well as policies and procedures for administering first aid?

9. Does the Head Start Director have access to the "Guide for Health Services" revised edition of 1967 and distributed by the Office of Economic Opportunity?

10. Has <u>every</u> aspect of the Health Program (listed on the "Planning Checklist" in Kit) been considered in the consultation process?

11. What plans are being made to provide "feed-back" to Head Start Directors?

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* From paper entitled "Project Head Start - Its Implications for School Health" presented by A. Frederick North, Jr., M.D., at the 95th Annual Meeting, A.P.H.A., Miami Beach, Florida, October 25, 1967.

Appendix H-4

Dental Health Consultation:

For the first time, Dental Consultation will be provided through a cooperative arrangement whereby the Dental Division and the Massachusetts Dental Society will mobilize the dental resources in a given community, if necessary. It is not anticipated that a representative of the dental profession will accompany the Head Start Consultation Team in its initial visit to a local program.

The suggested procedure is to have the Public Health Generalist work closely with the district dental hygienist in reviewing the local Project Dental Program and in anticipating any possible problems, in advance of the initial Team visit. Thereafter, should a problem arise, Dr. Alexander Maitland has suggested the following steps:

If problem arises in program X --

1. Initial calls should be directed to dental hygienist in district (regional) health offices. District (region) attempt is made to solve problem.

2. If problem persists, it could then be forwarded by the dental hygienist to the Division of Dental Health, attention of Dr. Maitland. Hopefully, solution could be reached and all concerned kept informed.

3. If solution of problem not attainable, Dr. Maitland will make appointment with appropriate local director and the regional dental consultant (appointed by the Massachusetts Dental Society) could be arranged.

4. The Division of Dental Health will provide support to the dental profession and local program directors in the area of program review, self-assessment of dental program and adequate reporting, record keeping and follow through procedures for continuity of care. (A self-assessment sheet entitled "Suggestions for Evaluation of Dental Program" is included in Kit.)

Mental Health Consultation:

The Department of Mental Health has indicated its willingness to cooperate in the 1968 Program. However, they are still in the process of reorganization and staffing local programs. Liaison staff, Dr. Herbert Siegert, has provided the names of Regional Mental Health Administrators for Public Health Generalists to contact. Each Kit contains such a name (or a substitute). It is hoped that a staff person who might serve as a "mental health generalist" will be available and assigned to serve on the Consultation Team.

Appendix H-3

Pediatric Consultation:

Dr. Allan Stimson is Chairman of the Committee on Head Start of the Massachusetts Chapter of the American Academy of Pediatrics. He maintains effective communication via Newsletter with the Massachusetts membership, has developed the List of Pediatric Consultants, and approved their community assignments, evaluations, and fee schedules.

The report forms (see Consultant's Report in Kit) and other procedures which have been standardized for the program of the American Academy of Pediatrics under contract with the Office of Economic Opportunity will be adhered to in Massachusetts. Pediatricians will not serve as consultants in the communities where they practice, but every attempt will be made for them to provide consultive service in nearby communities.

Public Welfare Consultation:

As during 1967, the Massachusetts Department of Public Welfare will cooperate and has designated the name of the regional Welfare individual who will be responsible for assignment of a staff member to the Consultation Team. There have been no changes in Medicaid procedures or eligibility requirements. "The Declaration of Need for Medical Assistance" form has been revised. (See Kit.)

Nutrition Consultation:

Nutrition consultation is available in all Regional Health Offices to assist program directors in regard to problem of food service, or parent and child education. Frequently local nutrition resource people such as home economist, dietitian, or college student can assist the director when called upon.

Knowledge of nutrition and homemaking skills can provide for a "healthier" family and thought should be given to strengthening the family education portion of the program. (See Head Start Nutrition Kit).

All school lunch equipment can usually be obtained for the lunch program under an agreement with the local Board of Education. Although OEO provides a flat fee for food per day (50¢/child) additional foods are available to the program through School Lunch and should be utilized whenever possible to "stretch" the food allowance.

Head Start Advisory Committee

Frances Heald
Sophie Kasparovich
Muriel LeMay
Gertrude Milliken
Ann Prendergast
Hedwig Sorli, Coordinator
Ex Officio: Dr. M. Grace Hussey

3/68

appendix I

HEAD START

GUIDE TO USE OF

PUBLIC HEALTH GENERALIST'S REPORT

PURPOSE

1. To provide a continuing tally of all contacts made in relation to Head Start.
2. To record on-going program progress.
3. To document amount of time spent in providing consultation.
4. To gather information which will help to identify the contributions made by the Public Health Generalist; to achieve more effective participation in planning and implementing the health components of Head Start Programs.
5. To assist the individual Public Health Generalist to complete O.E.O. reports required at the end of the program.

DIRECTIONS

1. Use reverse side of sheet if you need more space.
2. Except for Item #10, all items completed should reflect total "team" efforts, as seen by the Public Health Generalist.
3. Item 2 - "Time Spent" - refers to the particular contact described in the report.
4. Complete one report after every contact and send a duplicate copy to:

Mrs. Hedwig M. Sorli
Head Start Project Coordinator
Division of Maternal and Child Health Services
88 Broad Street, Boston, Mass. 02110

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appendix J

HEAD START

PUBLIC HEALTH GENERALIST'S REPORT

Name of Public Health Generalist _____

1. NAME OF HEAD START PROGRAM _____ Community _____

2. DATE OF GENERALIST'S ACTIVITY _____ TIME SPENT _____

3. TYPE OF CONTACT (check one); SITE VISIT___ MEETING___ TELEPHONE, etc._____
LETTER_____ OTHER (specify)_____

4. WITH WHOM WAS CONTACT MADE? _____ POSITION _____

5. PURPOSE OF CONSULTATION _____

_____

_____

6. PROBLEMS ENCOUNTERED _____

_____

_____

7. ACCOMPLISHMENTS _____

_____

_____

8. RECOMMENDATIONS _____

_____

_____

9. OTHER COMMENTS _____

_____

_____

10. SPECIFIC CONTRIBUTION OF PUBLIC HEALTH GENERALIST _____

_____

_____

Appendix K-1

TO: Generalist Consultants to Head Start Programs

FROM: Hedy Sorli

The attached statistical report form was found to be helpful to personnel in some of the Head Start programs last year. They thought it helped them to see more exactly what was done and where more emphasis needed to be placed in the future. It is simply one method of dealing with data that might otherwise be scattered through the health records.

If you think the Head Start program personnel with whom you'll be working would find the forms useful, more can be obtained through this office.

Statistical Report - Head Start Program (Health Services)

DATE:

Total Pupil Enrollment: _____

Name of Head Start Program _____

I. Immunizations	No. Pupils Completed prior to Head Start	No. Pupils Completed During Head Start	By whom: Private Physician, Clinic, etc.	No. Pupils not completed to date
Small pox vaccination				
D.P.T. (initial series)				
D.P.T. Booster #1				
Booster #2				
Polio Initial				
Boosters				
Measles				
Other (Specify)				

II. Screening Programs	Total Done	By Whom Done (Specify)	No. Pupils with Positive Findings	No. that completed referrals for further evaluation or Rx
Health Appraisal				
Lab. Work (Specify)				
Speech				
Vision				
Hearing				
T.B. Testing				
Psychological				
Other				

III. Referrals Made as Result of Head Start (other than above)

	Number Made	Number Completed
Mental Health Association		
Family Service		
Other		

COMMENTS ON ABOVE

Appendix K-

Revised

Statistical Data - Health Services in a Head Start Program

Date Report Submitted: _____
Name of Program: _____
Type (Year Round or Summer): _____
Date Program Began: _____
Date Program Ended: _____

TOTAL PUPILS ENROLLED: _____

I SCREENING PROGRAMS	Completed No.	%	By Whom Done (Specify)	No. Not Completed	Positive Findings No.	%	No. who completed referrals for further evaluation or R.
Health Appraisal							
Lab.-Urinalysis							
-Hematocrit or Hemo.							
Vision							
Hearing							
T.B. Testing							
Psychological							
Speech							
Dental							
Other							

II IMMUNIZATIONS	Completed PRIOR to Head Start No.	%	By whom:*	Completed DURING Head Start No.	%	By whom:*	Total Completed	NOT COMPLETED to date No.	%
Small pox vaccination									
D.P.T. (initial series)									
D.P.T. Booster #1									
Booster #2									
Polio Initial									
Boosters									
Measles									
Other (Specify)									

III Referrals Made as Result of Head Start (other than above)

	No. Made	No. Completed
Mental Health Association		
Family Service		
Other		

*Designate by Private M.D., Clinic, etc.

COMMENTS ON ABOVE (If more space is needed, use reverse side.)

7/68 -- 250

Appendix L

Appendix M-1

HEAD START

Suggestions for Evaluation of Dental Program

1. Did all concerned agencies attend planning stages for program?

   Local Dental Representation
   Local or Regional Welfare Department
   Local Education Department
   Parents Representatives and Health aides

2. Were all segments of program discussed?

   (a) Mobilization of services - Certified list of Registered dentists in Massachusetts
   (b) Services to be provided
   (c) List of local dentists who would participate- (if family without services of a dentist.)

3. Were the following items discussed?

   (a) Methods of payment - Title XIX ___ Other ___
   (b) Scheduling of appointments, transportation and responsibility to ensure this.
   (c) Handling of problems or complaints
   (d) Establishment of priorities

4. Did all children receive necessary basic care?

5. Are children and parents instructed in elements of good oral hygiene? - Dental health education incorporated into program.

6. Were communications between director of program and dental profession adequate?

Check list of information

1. Number of children enrolled in the program (age and sex)
2. Number of children dropped from program (why)
3. Number of children admitted during program
4. Number at end of program
5. Records of past care, present needs and treatment services
6. Number of children receiving , and utilizing prescriptive fluorides. *Exceptions; Communities presently having fluoride adjusted water supplies.

Appendix M-2

HEAD START (continued)

7. Children not needing treatment

8. Children completing all necessary treatment

9. Cost of treatment per child in program - cost of treatment per fully treated child in program

10. Number of children treated with funds other than XIX

11. Total funds for project

12. Total funds for health services

13. Total funds for dental services

*Has Adequate Follow-up of Children been provided for, to ensure the future Referral and Continuity of Care in the Elementary School System

Appendix N-1

MEMORANDUM

To: Public Health Generalists

From: Hedy Sorli
Head Start Project Coordinator

Date: October 28, 1968

Subject: December 1st, 1968
Closing date for submitting Summer, 1969
Head Start applications

Massachusetts CAP Staff recently have been informed of a December 1st deadline for submitting written project applications to the New York OEO Office for Summer, 1969 Head Start Programs funding.

Almost universally, evaluations of Summer, 1968 Consultation experiences indicate the need for earlier involvement of Consultant Teams during the planning phases of local Head Start Health Services Programs.

If your Health Services recommendations are to be implemented, we ask you to contact your Head Start administrators as soon as possible!

Miss Nan Maguire, Head Start Coordinator of the Technical Assistance Office, is simultaneously sending a memorandum to all Head Start and CAP directors, indicating the need to get in touch with the Health Consultation Team while projects are in the planning stages.

Appendix N-2

MEMORANDUM

To: Public Health Generalists

From: Hedy Sorli
Head Start Project Coordinator

Date: October 28, 1968

Subject: Procedural Change in Application Forms

For your general information, the OEO Office has revised its forms for project applications for Head Start proposals.

From now on, Proposals will not be required to have a narrative or check list description of the proposed health services programs. This means that it will not be possible for us to send you descriptive Profiles in 1969.

OEO rationale behind this simplification of procedures is to allow more time to be spent in planning a good program.

Appendix B

MEMORANDUM

To:

From: Hedy Sorli
Head Start Project Coordinator

Date: January 23, 1969

Subject: Head Start Health Services Consultation Report

At the Day Care Staff Meeting on Friday, January 17th (with the Regional Day Care Coordinators) we reported to them on program developments. The tabulation of data on evaluation of Summer Head Start Programs by Bio-dynamics for the entire country is now completed. Your Regional Coordinator will distribute to you (if completed) the Medical Consultant's Evaluation Form (CAP HS-48) for your community. We are cross-tabulating the data you supplied on HS-48 together with that of the pediatricians.

Statistical information as well as the information you have provided in your verbal and narrative reports will serve as the basis for a status Report required by our present contract with OEO. We are now preparing it.

If you have additional recommendations or suggestions for strengthening the program or any ideas which you would like to see incorporated in this Report to OEO, will you please send them preferably within the week? (With a deadline of January 31st.)

The Coordinators suggested that you jot your suggestions down on this memorandum and return the sheet. If you have no further recommendations, we would appreciate a return of this memorandum, too, with the word "None". (A self-addressed stamped envelope is attached.)

I appreciate your ever-generous cooperation in providing feed-back!

HMS/ab
Enc.

To: Appendix P

The Commonwealth of Massachusetts

Department of Public Health

Division of Maternal and Child Health Services

88 Broad Street, Boston 02110

MEMORANDUM

To: Head Start Consultants

From: Hedwig Sorli -- for the
Interdepartmental Conference
Planning Committee

Date: December 13, 1967

SUBJECT: REGIONAL MEETING DATES

We would like to alert you to the following schedule of meetings. Instead of a single follow-up Consultants' Conference it was decided to hold three similar meetings in locations accessible to the invited participants.

For the SOUTHEASTERN AREA	January 17, 1968 at the Southeastern Regional Health office, Lakeville
Host Agency	Mass. Department of Public Health
For the NORTHEASTERN AREA	January 24, 1968 at the North Reading Rehabilitation Center
Host Agency	Mass. Department of Mental Health
For the CENTRAL & WESTERN AREAS	January 31, 1968 at the Springfield District Office, D.P.W.
Host Agency	Mass. Department of Public Welfare

The meetings are being planned to report on the evaluation of last summer's Head Start Health Program Consultation Teams and to develop realistic goals and orientation for health specialists who will be assisting with consultation to the "all-year program" as well as summer programs planned for 1968.

You will be receiving further details of these meetings and written reports in advance of the dates. However, we would appreciate it if you would circle the appropriate date on your calendar so that you will attend the meeting planned for your own geographical area.

INTERDEPARTMENTAL PLANNING COMMITTEE

Aaron Coville	Joan Power
John Milan	Herbert Siegert, M.D.
Nan McGuire	Hedwig Sorli

Appendix Q

3 REGIONAL HEAD START CONFERENCES

Southeast - Lakeville
Northeast - North Reading
Western - Springfield

WHO'S WHO
among Program Participants

CHAIRMAN — Leon Sternfeld, M.D., Deputy Commissioner & Director of Local Health Services, Massachusetts Department of Public Health

SPEAKERS — Joan Power, Project Coordinator (Head Start Consultation Pgrm., Benjamin Sachs, M.D., Project Director (Summer, 1967, M.D.P.H.

RESOURCE PANEL

1. Commonwealth Service Corps
   Nan McGuire, Coordinator of Head Start, Commonwealth Service Corps

2. Dental Health
   Alexander Maitland, D.M.D., Assistant Director, Division of Dental Health, M.D.P.H.

3. Mental Health
   - Southeast - B. R. Hutcheson, M.D., Asst. Comm., Child He. Services, Mass. Department of Mental Health
   - Northeast - E. George Cloutier, M.D., Regional Administrator, Region IV, M.D.M.H.
   - Western - Herbert Siegert, M.D., M.D.M.H.

4. Pediatricians
   - Southeast - Allan Stimson, M.D., Chrm., Hd. Start Comm., Mass. Chapter, American Academy of Pediatrics
   - Northeast - Sprague Hazard, M.D., Chairman, Mass. Chapter, A.A.P.
   - Western - Arthur Maislen, M.D., Mass. Chapter, A.A.P.

5. Public Health
   - Southeast - M. Grace Hussey, M.D., Director*
   - Northeast)
   - Western) Hedwig M. Sorli, Coordinator of He. Education*
   - *Div. of Mat.&Ch. Health Services, M.D.P.H.

6. Public Welfare
   - Southeast - John Milan, Supervisor of Social Service**
   - Northeast)
   - Western) Aaron Coville, Supervisor of Social Service**
   - **Division of Field Operations, Massachusetts Department of Public Welfare

INTERDEPARTMENTAL PLANNING COMMITTEE

Aaron Coville	Joan Power
John Milan	Herbert Siegert, M.D.
Nan McGuire	Hedwig Sorli

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Appendix R

STATISTICS FROM

MEDICAL CONSULTANT'S EVALUATION OF
HEAD START HEALTH SERVICES
(CAP-HS FORM 48)

For The 1969 Summer Head Start Programs
in Massachusetts

bio-dynamics inc.

STATISTICS FROM

MEDICAL CONSULTANT'S EVALUATION OF HEAD START HEALTH SERVICES (CAP-HS FORM 48)

For The 1969 Summer Head Start Programs
in Massachusetts

Prepared for

The Commonwealth of Massachusetts
Department of Public Health

by

Thomas F. Sullivan

Utilizing Data Reporting Format Developed by Staff of Maternal and Child Health Services of the Massachusetts Department of Public Health

Bio-Dynamics, Inc.
33 Cambridge Parkway
Cambridge, Massachusetts 02142

March 24, 1970

bio-dynamics inc.

This report is based on data submitted to the Massachusetts Department of Public Health by Pediatric Consultants and Public Health Generalists assigned to advise the health components of the 1969 Summer Head Start programs in Massachusetts.

Data were submitted by both the Pediatricians and the Generalists on CAP-HS Form 48, Medical Consultant's Evaluation of Head Start Health Services. This form is shown as Figure 1 in this report.

MEDICAL CONSULTANT'S EVALUATION OF HEAD START HEALTH SERVICES	DATE OF EVALUATION	*Form Approved Budget Bureau No. 116-R0119* *REPORTS CONTROL SYMBOL OEO-CHE13*

NAME, ADDRESS AND TELEPHONE OF GRANTEE	NAME AND ADDRESS OF CONSULTANT

NAME, ADDRESS AND TELEPHONE OF DELEGATE AGENCY *(if different than Grantee)*

INSTRUCTIONS

Each medical consultant should complete a copy of this form for each health program which he visits and evaluates. Usually, one for each grantee. When differing health programs serve different delegate agencies under the same grantee, the consultant may submit a separate report for each such health program.

The questions are subjective and evaluative because simple factual data can be gathered directly from the project without using the time and talent of consultants. The answers should be based on the consultant's total evaluation after talking with the many people concerned with the Head Start Health Program; teachers, physicians, the health director, the Head Start director, parents, and others. The consultants should attempt to obtain sufficient information to make a judgment about each of the questions asked. Whenever possible, he should examine individual health records and program records in order to obtain objective information on which to base his subjective opinion.

The consultant should feel free to discuss his evaluation with those responsible for the Health Program. He may wish to give a copy of this evaluation report directly to the health director or program director. Any findings or recommendations which he feels could not be productively utilized by the local program, but which are important to the Regional or National OEO Office, should be reported by letter.

I. PLANNING

1. Which of the following were substantially involved in PLANNING the Head Start Health Program? *(had a large enough role to feel some responsibility for results)*

- ☐ HEALTH DEPARTMENT
- ☐ WELFARE DEPARTMENT
- ☐ SCHOOL HEALTH PROGRAM
- ☐ MEDICAL SOCIETY
- ☐ PEDIATRIC ASSOCIATION
- ☐ DENTAL SOCIETY

2. How successful was the health program in obtaining meaningful participation of all important community health resources in planning the Head Start Health Program?

- ☐ VERY SUCCESSFUL *(most existing agencies and practitioners participated)*
- ☐ PARTIALLY SUCCESSFUL
- ☐ LITTLE SUCCESS *(program planned and executed by a single physician or agency or only a few)*

3. Did the PLAN for health services appear to be adequate to meet the health goals of Project Head Start? *(disregard difficulties in implementation not inherent in the plan itself)*

- ☐ SUPERIOR PLAN
- ☐ ADEQUATE PLAN
- ☐ PLAN WITH INADEQUACIES
- ☐ GENERALLY INADEQUATE PLAN

II. PROGRAM

4. Were participating physicians well informed about goals and guidelines of Head Start Health Programs and their precise roll in it?

- ☐ VERY WELL INFORMED
- ☐ ADEQUATELY INFORMED
- ☐ INADEQUATELY INFORMED

5. Was the medical program carried out in such a way as to be convenient, comfortable and dignified for the children and parents? Did the participating physicians appear to be concerned about the dignity and comfort of the Head Start children and parents?

- ☐ VERY MUCH SO *(private patient status or better)*
- ☐ TO A LARGE EXTENT
- ☐ TO ONLY A SMALL EXTENT *(hard benches, long waits, impersonal treatment, "mass production" exams)*

6. Were parents present at the time of the physician's health evaluation?

- ☐ ALMOST UNIVERSALLY SO (95%+)
- ☐ LESS OFTEN *(estimate percentage)* _____ %
- ☐ INFREQUENTLY *(less than 15%)*

II. PROGRAM *(Continued)*

7. Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components.

- ☐ WELL INTEGRATED AND COORDINATED
- ☐ PERIPHERAL TO REST OF PROGRAM BUT NOT DISRUPTIVE
- ☐ SCHEDULED SO AS TO DISRUPT OR INTERFERE WITH OTHER COMPONENTS OF PROGRAM

8. Was the health program planned and organized so that children could obtain continuing care *(during and after Head Start)* from the physician examining and treating him in Head Start?

- ☐ TO A GREAT EXTENT (80%+ *of children)*
- ☐ TO A MODERATE EXTENT
- ☐ TO LITTLE OR NO EXTENT *(25% or less)*

III. RECORDS

9. Were individual health records of sufficient detail and quality to serve as a basis for all future treatment and health supervision? *(so that you would require little further history if child came to your office for care)*

- ☐ VERY MUCH SO
- ☐ ADEQUATE
- ☐ INADEQUATE

10. Was there a checksheet, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?

☐ YES ☐ NO

Did it accomplish its purpose?

- ☐ ADEQUATELY
- ☐ INADEQUATELY

11. Were health program records, statistics and summaries adequate to serve as a basis for realistic planning and budgeting of FUTURE health programs?

- ☐ VERY MUCH SO *(clear record of activities, findings, treatment results and costs)*
- ☐ ADEQUATE *(some record of immunizations, findings on tests, exams, costs)*
- ☐ INADEQUATE

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IV. SUMMARY EVALUATION

12. How well did this program succeed in achieving each of the goals listed below?	HIGH SUCCESS	MODERATE SUCCESS	SLIGHT SUCCESS
a. Finding Health Defects through:			
TEACHER'S OBSERVATIONS			
SCREENING TESTS			
PHYSICIAN'S EXAMINATION			
PAST HEALTH RECORDS			
b. Treating Health Defects			
MEDICAL			
DENTAL			
PSYCHOLOGICAL			
c. Preventing Future Health Problems through:			
IMMUNIZATIONS			
FLOURIDE DENTAL TREATMENT			
HEALTH EDUCATION			
INTRODUCING CHILD TO PHYSICIAN AND			
DENTIST WHO CAN PROVIDE FUTURE CARE			
d. Improving Health of Family Members by:			
CALLING ATTENTION TO FAMILY HEALTH NEEDS			
INTRODUCING FAMILY TO SOURCES OF HEALTH CARE FUNDS AND SERVICES			
e. Improving the Health of the Community through:			
INCREASING AWARENESS OF HEALTH PROBLEMS OF POOR CHILDREN			
STIMULATING NEW RESOURCES TO PROVIDE AND PAY FOR CHILD HEALTH CARE			
MAKING EXISTING RESOURCES MORE RESPONSIVE TO THE SPECIAL NEEDS OF THE POOR			

V. IMPACT

13. To what extent did the Head Start Health program provide services which these children would not have obtained *(or would have obtained only after significant delay)* without Head Start?	LARGE EXTENT	MODERATE EXTENT	SMALL OR NO EXTENT
SCREENING TESTS			
MEDICAL HISTORY AND EXAMINATION			
MEDICAL TREATMENT			
DENTAL TREATMENT			
IMMUNIZATIONS			

VI. THE CONSULTATION PROCESS

14. In the course of your consultation did you

- ☐ MEET WITH COMMUNITY ACTION AGENCY DIRECTOR OR HIS REPRESENTATIVE
- ☐ MEET WITH HEAD START DIRECTOR
- ☐ MEET WITH HEAD START PARENTS
- ☐ VISIT A HEAD START CLASSROOM IN ACTION
- ☐ MEET WITH LOCAL MEDICAL SOCIETY OR ITS OFFICERS
- ☐ MEET WITH LOCAL HEALTH OFFICER OR HIS REPRESENTATIVE
- ☐ MEET OR TALK ON TELEPHONE WITH ANALYST OR FIELD REPRESENTATIVE IN OEO REGIONAL OFFICE

15. In which of the following ways were you able as a consultant to help?	MAJOR IMPACT	MINOR IMPACT	NONE
a. SOLICITING INTEREST AND PARTICIPATION FROM LOCAL PHYSICIANS			
b. IDENTIFYING AND ARRANGING FOR USE OF EXISTING HEALTH CARE SERVICES AND FUNDS			
c. OBTAINING INTEREST AND PARTICIPATION FROM LOCAL HEALTH AND WELFARE AGENCIES			
d. IMPROVING THE PLANNING PROCESS AND ORGANIZATIONAL PATTERNS			
e. SUGGESTING BETTER METHODS OF SCREENING, EXAMINING, TREATING OR PROVIDING HEALTH EDUCATION			

16. Give one example of how you, as a consultant, contributed to the Health Services Program of the grantee.

17. What is your estimate of the value of the consultation program in improving the quality of health care for Head Start children?

- ☐ WORTHWHILE AND SHOULD BE CONTINUED
- ☐ WORTHWHILE IF MODIFIED
- ☐ NOT WORTHWHILE AND SHOULD NOT BE CONTINUED

What modifications would you suggest?

Reports were received from twenty-two Pediatricians and twenty-six Public Health Generalists. Figure 2 shows the programs from which these reports were received.

Figure 2

Summer Head Start Program Locations	CAP-HS Form 48 Received From	
	Pediatricians	Public Health Generalists
Ashburnham	x	x
Athol		x
Boston	x	
Bourne		x
Chelsea - Revere	x	x
Chicopee	x	x
Fairhaven	x	x
Falmouth	x	
Franklin County	x	x
Gardner	x	x
Gloucester - Middleton	x	x
Hampshire Co. (Northampton, etc.)		x
Haverhill	x	x
Lawrence	x	x
Lunenburg		x
Malden - Somerville	x	x
Mashpee	x	
New Bedford	x	x
Salem	x	x
School Union #1	x	x
South Shore (Marshfield)		x
South Shore (Plymouth)	x	x
Southbridge	x	
Southern Berkshire	x	x
Southern Middlesex	x	x
Townsend		x
WEMBROC		x
Westfield		x
Wilmington		x
Winchendon	x	x
Worcester	x	
Total	22	26

This report presents tabulations of responses to each of the questions on CAP-HS Form 48. There has been no attempt to cross-tabulate the responses of the pediatricians with those of the public health generalists.

This report does present the 1969 data for each question on the same page with or on the page immediately preceding the 1968 data for each question. The 1968 data are taken from the Report on Program of Medical and Public Health Consultation to Project Head Start in Massachusetts which was prepared by the Massachusetts Department of Public Health.

Table 1. REPLIES TO QUESTION 1. ON PLANNING OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Which of the following were substantially involved in planning the Head Start Program?				
Health Department	10	45%	13	50%
Welfare Department	16	73%	16	61%
School Health Program	13	59%	16	61%
Medical Society.....	1	4%	1	4%
Pediatric Association	3	14%	1	4%
Dental Society	3	14%	4	15%
None	2	9%	2	8%
No Answer	1	4%	2	8%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Which of the following were substantially involved in planning the Head Start Program?				
Health Department	19	58%	17	49%
Welfare Department	22	67%	27	77%
School Health Program	21	64%	24	69%
Medical Society.....	3	9%	3	9%
Pediatric Association	9	27%	4	11%
Dental Society	6	18%	7	20%

Table 2. REPLIES TO QUESTION 2. ON PLANNING OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
How successful was the health program in obtaining meaningful participation of all important community health resources in planning the Head Start Health Program?				
Very successful	4	18%	8	31%
Partially successful	14	64%	13	50%
Little Success	4	18%	5	19%
No Answer	0	0	0	0

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
How successful was the health program in obtaining meaningful participation of all important community health resources in planning the Head Start Health Program?				
Very successful	11	33%	12	34%
Partially successful	13	39%	14	40%
Little success	9	27%	8	23%
No answer	0	0	1	3%

Table 3. REPLIES TO QUESTION 3. ON PLANNING OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Did the PLAN for health services appear to be adequate to meet the health goals of Project Head Start?				
Superior plan	6	27%	7	27%
Adequate plan	12	54%	11	42%
Plan with inadequacies	1	4%	6	23%
Generally inadequate plan	3	14%	1	4%
No answer	0	0	1	4%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Did the PLAN for health services appear to be adequate to meet the health goals of Project Head Start?				
Superior plan	9	27%	8	23%
Adequate plan	16	48%	19	54%
Plan with inadequacies	6	18%	8	23%
Generally inadequate plan	1	3%	0	0
No answer	1	3%	0	0

Table 4. REPLIES TO QUESTION 4. ON PROGRAM OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were participating physicians well informed about goals and guidelines of Head Start Health Programs and their precise role in it?				
Very well informed	9	41%	11	42%
Adequately informed	10	45%	10	38%
Inadequately informed	3	14%	4	15%
No answer	0	0	1	4%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were participating physicians well informed about goals and guidelines of Head Start Health Programs and their precise role in it?				
Very well informed	8	24%	8	23%
Adequately informed	17	52%	17	49%
Inadequately informed	6	18%	10	29%
No answer	2	6%	0	0

Table 5. REPLIES TO QUESTION 5. ON PROGRAM OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the medical program carried out in such a way as to be convenient, comfortable and dignified for the children and parents? Did the participating physicians appear to be concerned about the dignity and comfort of the Head Start children and parents?				
Very much so	13	59%	16	61%
To a large extent	8	36%	7	27%
To only a small extent	0	0	1	4%
No answer	1	4%	2	8%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the medical program carried out in such a way as to be convenient, comfortable and dignified for the children and parents? Did the participating physicians appear to be concerned about the dignity and comfort of the Head Start children and parents?				
Very much so	16	48%	20	57%
To a large extent	11	33%	10	29%
To only a small extent	3	9%	2	6%
No answer	3	9%	3	9%

Table 6. REPLIES TO QUESTION 6. ON PROGRAM OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were parents present at the time of the physician's health evaluation?				
Almost universally so	14	64%	18	69%
Less often	4	18%	3	11%
Infrequently	3	14%	3	11%
No answer	1	4%	2	8%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were parents present at the time of the physician's health evaluation?				
Almost universally so	24	73%	30	86%
Less often	7	21%	2	6%
Infrequently	0	0	1	3%
No answer	2	6%	2	6%

Table 7. REPLIES TO QUESTION 7. ON PROGRAM OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components?				
Well integrated and coordinated	15	68%	17	65%
Peripheral to rest of program but not disruptive	6	27%	7	27%
Scheduled so as to disrupt or interfere with other components of program	1	4%	1	4%
No answer	0	0	1	4%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the health services program planned and scheduled so that it was an integral part of the total child development program, drawing strength from and contributing to the nutritional, educational, psychological and social services components?				
Well integrated and coordinated	19	58%	22	63%
Peripheral to rest of program but not disruptive	11	33%	13	37%
Scheduled so as to disrupt or interfere with other components of program	0	0	0	0
No answer	3	9%	0	0

Table 8. REPLIES TO QUESTION 8. ON PROGRAM OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the health program planned and organized so that children could obtain continuing care from the physician examining and treating him in Head Start?				
To a great extent	9	41%	15	58%
To a moderate extent	7	32%	10	38%
To little or no extent	5	23%	1	4%
No answer	1	4%	0	0

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was the health program planned and organized so that children could obtain continuing care from the physician examining and treating him in Head Start?				
To a great extent	19	58%	22	63%
To a moderate extent	7	21%	11	31%
To little or no extent	6	18%	2	6%
No answer	1	3%	0	0

Table 9. REPLIES TO QUESTION 9. ON RECORDS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were individual health records of sufficient detail and quality to serve as a basis for all future treatment and health supervision?				
Very much so	11	50%	14	54%
Adequate	8	36%	10	38%
Inadequate	3	14%	1	4%
No answer	0	0	1	4%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were individual health records of sufficient detail and quality to serve as a basis for all future treatment and health supervision?				
Very much so	14	42%	20	57%
Adequate	14	42%	10	29%
Inadequate	5	15%	5	14%

Table 10. REPLIES TO QUESTION 10. ON RECORDS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was there a checksheet, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?				
*Yes	20	91%	20	77%
No	1	4%	2	8%
No answer	1	4%	4	15%
*Total - Yes	20	100%	20	100%
Did it accomplish its purpose?				
Adequately	19	95%	18	90%
Inadequately	0	0	1	5%
No answer	1	5%	1	5%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Was there a checksheet, tickler file or other system to be sure that each child received all recommended screening tests, preventive measures, and treatment?				
*Yes	28	85%	32	91%
No	4	12%	1	3%
No answer	1	3%	2	6%
*Total - Yes	28	100%	32	100%
Did it accomplish its purpose?				
Adequately	25	89%	29	91%
Inadequately	2	7%	1	3%
No answer	1	4%	2	6%

Table 11. REPLIES TO QUESTION 11. ON RECORDS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were health program records, statistics and summaries adequate to serve as a basis for realistic planning and budgeting of future health programs?				
Very much so	11	50%	14	54%
Adequate	10	45%	11	42%
Inadequate	1	4%	0	0
No answer	0	0	1	4%

Tabulations from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
Were health program records, statistics and summaries adequate to serve as a basis for realistic planning and budgeting of future health programs?				
Very much so	13	39%	15	43%
Adequate	15	45%	18	51%
Inadequate	5	15%	2	6%

Table 12. REPLIES TO QUESTION 12. a. ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
a. Finding health defects through:										
Teacher's observations										
Pediatricians	22	100	4	18	15	68	1	4	2	9
Generalists	26	100	12	46	11	42	3	11	0	0
Screening tests										
Pediatricians	22	100	13	59	5	23	3	14	1	4
Generalists	26	100	15	58	10	38	0	0	1	4
Physician's examination										
Pediatricians	22	100	10	45	8	36	3	14	1	4
Generalists	26	100	14	54	8	31	3	11	1	4
Past health records										
Pediatricians	22	100	2	9	12	54	7	32	1	4
Generalists	26	100	6	23	9	35	6	23	5	19

Tabulations from Reports for Summer, 1968

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
a. Finding health defects through										
Teacher's observations										
Pediatricians	33	100	15	45	10	30	6	18	2	6
Generalists	35	100	17	49	11	31	5	14	2	6
Screening tests										
Pediatricians	33	100	18	55	9	27	6	18	0	0
Generalists	35	100	21	60	10	29	3	9	1	3
Physician's examination										
Pediatricians	33	100	15	45	14	42	3	9	1	3
Generalists	35	100	20	57	10	29	4	11	1	3
Past health records										
Pediatricians	33	100	7	21	14	42	10	30	2	6
Generalists	35	100	9	26	12	34	11	31	3	9

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Table 13. REPLIES TO QUESTION 12. b. ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the gcals listed below?										
b. Treating health defects										
Medical										
Pediatricians	22	100	9	41	11	50	1	4	1	4
Generalists	26	100	13	50	13	50	0	0	0	0
Dental										
Pediatricians	22	100	6	27	10	45	5	23	1	4
Generalists	26	100	7	27	14	54	5	19	0	0
Psychological										
Pediatricians	22	100	3	14	8	36	9	41	2	9
Generalists	26	100	10	38	11	42	4	15	1	4

Tabulations from Reports for Summer, 1968

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
b. Treating health defects										
Medical										
Pediatricians	33	100	20	61	8	24	5	15	0	0
Generalists	35	100	21	60	10	29	3	9	1	3
Dental										
Pediatricians	33	100	10	30	14	42	7	21	2	6
Generalists	35	100	7	20	18	51	9	26	1	3
Psychological										
Pediatricians	33	100	4	12	18	55	9	27	2	6
Generalists	35	100	11	31	14	40	6	17	4	11

Table 14. REPLIES TO QUESTION 12. c. ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
c. Preventing future health problems through:										
Immunizations										
Pediatricians	22	100	14	64	3	14	3	14	2	9
Generalists	26	100	14	54	9	35	2	8	1	4
Flouride dental treatment										
Pediatricians	22	100	3	14	4	18	9	41	6	27
Generalists	26	100	6	23	5	19	8	31	7	27
Health education										
Pediatricians	22	100	5	23	7	32	6	27	4	18
Generalists	26	100	6	23	11	42	7	27	2	8
Introducing child to physician who can provide future care										
Pediatricians	22	100	8	36	6	27	4	18	4	18
Generalists	26	100	9	35	11	42	4	15	2	8
Introducing child to dentist who can provide future care										
Pediatricians	22	100	4	18	8	36	5	23	5	23
Generalists	26	100	4	15	11	42	6	23	5	19

Table 14, continued

Tabulations from Reports for Summer, 1968

	Degree of Success in Achieving Specified Goals									
	All Replies		High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
c. Preventing future health problems through:										
Immunizations										
Pediatricians	33	100	19	58	11	33	3	9	0	0
Generalists	35	100	20	57	10	29	4	11	1	3
Fluoride dental treatment										
Pediatricians	33	100	4	12	5	15	19	58	5	15
Generalists	35	100	6	17	7	20	12	34	10	29
Health education										
Pediatricians	33	100	10	30	15	45	7	21	1	3
Generalists	35	100	10	29	14	40	10	29	1	3
Introducing child to physician who can provide future care										
Pediatricians	33	100	12	36	11	33	8	24	2	6
Generalists	35	100	14	40	13	37	7	20	1	3
Introducing child to dentist who can provide future care										
Pediatricians	33	100	10	30	13	39	6	18	4	12
Generalists	35	100	9	26	14	40	12	34	0	0

Table 15. REPLIES TO QUESTION 12. d. ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
d. Improving health of family members by:										
Calling attention to family health needs										
Pediatrician	22	100	6	27	9	41	4	18	3	14
Generalists	26	100	9	35	12	46	5	19	0	0
Introducing family to sources of health care funds and services										
Pediatricians	22	100	6	27	9	41	3	14	4	18
Generalists	26	100	10	38	10	38	5	19	1	4

Tabulations from Reports for Summer, 1968

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
d. Improving health of family members by:										
Calling attention to family health needs										
Pediatricians	33	100	14	42	11	33	7	21	1	3
Generalists	35	100	14	40	12	34	8	23	1	3
Introducing family to sources of health care funds and services										
Pediatricians	33	100	16	48	11	33	4	12	2	6
Generalists	35	100	18	51	13	37	3	9	1	3

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Table 16. REPLIES TO QUESTION 12. e. ON SUMMARY EVALUATION OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
e. Improving the health of the community through:										
Increasing awareness of health problems of poor children										
Pediatricians	22	100	3	14	13	59	3	14	3	14
Generalists	26	100	7	27	13	50	6	23	0	0
Stimulating new resources to provide and pay for child health care										
Pediatricians	22	100	2	9	3	14	12	54	5	23
Generalists	26	100	5	19	5	19	12	46	4	15
Making existing resources more responsive to the special needs of the poor										
Pediatricians	22	100	4	18	10	45	5	23	3	14
Generalists	26	100	7	27	11	42	6	23	2	8

Table 16, continued

Tabulations from Reports for Summer, 1968

	All Replies		Degree of Success in Achieving Specified Goals: High Success		Moderate Success		Slight Success		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
How well did this program succeed in achieving each of the goals listed below?										
e. Improving the health of the community through:										
Increasing awareness of health problems of poor children										
Pediatricians	33	100	15	45	9	27	7	21	2	6
Generalists	35	100	13	37	10	29	11	31	1	3
Stimulating new resources to provide and pay for child health care										
Pediatricians	33	100	5	15	11	33	13	39	4	12
Generalists	35	100	9	26	4	11	17	49	5	14
Making existing resources more responsive to the special needs of the poor										
Pediatricians	33	100	8	24	13	39	7	21	5	15
Generalists	35	100	10	29	6	17	15	43	4	11

Table 17. REPLIES TO QUESTIONS ON IMPACT OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Extent to Which Program Provided Services							
			Large Extent		Moderate Extent		Small Or No Extent		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
To what extent did the Head Start Health Program provide services which these children would not have obtained (or would have obtained only after significant delay) without Head Start?										
Screening tests										
Pediatricians	22	100	13	59	4	18	4	18	1	4
Generalists	26	100	17	65	9	35	0	0	0	0
Medical history and examination										
Pediatricians	22	100	10	45	7	32	4	18	1	4
Generalists	26	100	16	61	10	38	0	0	0	0
Medical treatment										
Pediatricians	22	100	5	23	8	36	7	32	2	9
Generalists	26	100	14	54	11	42	1	4	0	0
Dental treatment										
Pediatricians	22	100	8	36	8	36	5	23	1	4
Generalists	26	100	12	46	7	27	7	27	0	0
Immunizations										
Pediatricians	22	100	9	41	7	32	5	23	1	4
Generalists	26	100	9	35	9	35	7	27	1	4

Table 17, continued

Tabulations from Reports for Summer, 1968

	All Replies		Extent to Which Program Provided Services							
			Large Extent		Moderate Extent		Small Or No Extent		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
To what extent did the Head Start Health Program provide services which these children would not have obtained (or would have obtained only after significant delay) without Head Start?										
Screening tests										
Pediatricians	33	100	20	61	9	27	4	12	0	0
Generalists	35	100	26	74	7	20	2	6	0	0
Medical history and examination										
Pediatricians	33	100	17	52	11	33	5	15	0	0
Generalists	35	100	24	69	7	20	4	11	0	0
Medical treatment										
Pediatricians	33	100	13	39	13	39	7	21	0	0
Generalists	35	100	21	60	11	31	2	6	1	3
Dental treatment										
Pediatricians	33	100	15	45	12	36	5	15	1	3
Generalists	35	100	22	63	8	23	5	14	0	0
Immunizations										
Pediatricians	33	100	13	39	16	48	4	12	0	0
Generalists	35	100	13	37	15	43	5	14	2	6

Table 18. REPLIES TO QUESTION 14. ON THE CONSULTATION PROCESS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
In the course of your consultation did you				
Meet with community action agency director or his representative .	17	77%	13	50%
Meet with Head Start director . .	19	86%	25	96%
Meet with Head Start parents . .	5	23%	12	46%
Visit a Head Start classroom in action	11	50%	19	73%
Meet with local medical society or its officers	3	14%	1	4%
Meet with local health officer or his representative	7	32%	5	19%
Meet or talk on telephone with analyst or field representative in OEO regional office . .	3	14%	2	8%
No answer	0	0	0	0

Tabulations from reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
In the course of your consultation did you				
Meet with community action agency director or his representative .	21	64%	18	51%
Meet with Head Start director . .	33	100%	35	100%
Meet with Head Start parents . .	12	36%	9	26%
Visit a Head Start classroom in action	15	45%	20	57%
Meet with local medical society or its officers	3	9%	3	9%
Meet with local health officer or his representative	15	45%	7	20%
Meet or talk on telephone with analyst or field representative in OEO regional office . .	7	21%	4	11%

Table 19. REPLIES TO QUESTION 15. ON THE CONSULTATION PROCESS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	All Replies		Degree of Impact of Consultation: Major Impact		Minor Impact		None		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
In which of the following ways were you able as a consultant to help?										
Soliciting interest and participation from local physicians										
Pediatricians	22	100	1	4	6	27	14	64	1	4
Generalists	26	100	0	0	3	11	13	50	10	38
Identifying and arranging for use of existing health care services and funds										
Pediatricians	22	100	2	9	11	50	7	32	2	9
Generalists	26	100	3	11	13	50	4	15	6	23
Obtaining interest and participation from local health and welfare agencies										
Pediatricians	22	100	1	4	11	50	8	36	2	9
Generalists	26	100	6	23	11	42	5	19	4	15
Improving the planning process and organizational patterns										
Pediatricians	22	100	8	36	11	50	1	4	2	9
Generalists	26	100	4	15	12	46	2	8	8	31
Suggesting better methods of screening, examining, treating or providing health education										
Pediatricians	22	100	8	36	11	50	1	4	2	9
Generalists	26	100	6	23	11	42	3	11	6	23

Table 19, continued

Tabulations from Reports for Summer, 1968

	All Replies		Degree of Impact of Consultation: Major Impact		Minor Impact		None		No Answer	
	No.	%	No.	%	No.	%	No.	%	No.	%
In which of the following ways were you able as a consultant to help?										
Soliciting interest and participation from local physicians										
Pediatricians	33	100	4	12	11	33	16	48	2	6
Generalists	35	100	1	3	4	11	26	74	4	11
Identifying and arranging for use of existing health care services and funds										
Pediatricians	33	100	9	27	16	48	7	21	1	3
Generalists	35	100	6	17	12	34	13	37	4	11
Obtaining interest and participation from local health and welfare agencies										
Pediatricians	33	100	4	12	14	42	13	39	2	6
Generalists	35	100	6	17	12	34	15	43	2	6
Improving the planning process and organizational patterns										
Pediatricians	33	100	11	33	15	45	4	12	3	9
Generalists	35	100	8	23	21	60	6	17	0	0
Suggesting better methods of screening, examining, treating or providing health education										
Pediatricians	33	100	13	39	13	39	4	12	3	9
Generalists	35	100	9	26	17	49	6	17	3	9

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Table 20. REPLIES TO QUESTION 17. ON THE CONSULTATION PROCESS OF HEAD START HEALTH PROGRAM

Tabulations from Reports for Summer, 1969

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
What is your estimate of the value of the consultation program in improving the quality of health care for Head Start children?				
Worthwhile and should be continued .	15	68%	12	46%
Worthwhile if modified.	4	18%	13	50%
Not worthwhile and should not be continued	3	14%	1	4%

Tabulation from Reports for Summer, 1968

	Reports Submitted By: Pediatricians		Generalists	
	Number	Per Cent	Number	Per Cent
What is your estimate of the value of the consultation program in improving the quality of health care for Head Start children?				
Worthwhile and should be continued .	21	64%	12	34%
Worthwhile if modified.	10	30%	20	57%
Not worthwhile and should not be continued	2	6%	3	9%

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